Provider Synergies, an affiliate of Magellan Medicaid Administration,

Virginia Medicaid's Pharmacy Service Administrator

Phone: 1-800-932-6648 Fax: 1-800-932-6651

General Information:

- The PDL is a list of preferred drugs, by select therapeutic class, for which the Medicaid Fee-for-service program allows payment without requiring service authorization (SA).
- *Please note that not all drug classes are subject to the Virginia Medicaid PDL*. In the designated classes, drug products classified as non-preferred will be subject to SA. In some instances, additional clinical criteria may apply to a respective drug class which may require a SA.
- This is list is not all inclusive for non-preferred drugs.
- Fax requests receive a response within 24 hours.
- For urgent requests, please call **1-800-932-6648.**
- Not all drugs listed are covered by all DMAS programs.
- All new products included in a PDL class are non-preferred until reviewed by the P&T Committee.

PDL drug coverage information can be found at http://www.VirginiaMedicaidPharmacyServices.com. **The following "routine" PDL criteria guidelines will be applied to all non-preferred drugs. Some drug classes will have additional criteria that will be listed alongside the drug class.**

1. Is there any reason the patient cannot be changed to a preferred drug within the same class?
   Acceptable reasons include:
   - Allergy to preferred drug.
   - Contraindication to or drug-to-drug interaction with preferred drug.
   - History of unacceptable/toxic side effects preferred drug.
   - Patient's condition is clinically stable; changing to a preferred drug might cause deterioration of the patient's condition.

2. The requested drug may be approved if both of the following are true:
   - There has been a therapeutic failure of no less than a **one-month trial** of at least **one** preferred drug **within the same class**.
   - The requested drug's corresponding generic (if a generic is available **and** covered by the State) has been attempted and failed or is contraindicated.

All changes from last posting will be highlighted in yellow.

Teal highlights indicate where a Brand is preferred over a generic

Drugs no longer available have been removed from this list.

	Preferred Agents	Non-Preferred Agents	SA Criteria
Analgesics			
	*** Narcotics – Long Acting (LAN)**		
	fentanyl 25 mcg, 50 mcg, 75 mcg, 100 mcg patches **Kadian® ER** **morphine sulfate tab SA**	*Avinza®* *Belbuca™* *Butrans®* *Conzip ® ER* **Dolophine®* *Duragesic®* *Embeda* *Exalgo®* *fentanyl 37.5 mcg, 62.5 mcg, and 87.5 mcg patches* *Hysingla ER™* ***Methadose®* *morphine ER (generic for Avinza®)* *morphine ER (generic for Kadian®ER)* ***methadone 10 mg/5 mL & 5mg/5 mL oral soln* ***methadone 5 mg & 10 mg tab* *MS Contin®* *Nucynta® ER* *Opana® ER* *Oramorph ® SR®* *oxycodone-long acting* *OxyContin®* *oxymorphone ER* *Ryzolt™* *tramadol ER* *Ultram ER®* *Xartemis™XR)* *Zohydro ER™*	**LENGTH OF AUTHORIZATIONS**: • Up to three months after trial and failure of 2 different short acting narcotics for chronic non-malignant pain; **OR** • Up to one year for active cancer pain, palliative care, end-of-life care, or sickle cell **Routine PDL edit plus** ***Clinical Criteria for LAN (LAN fax form must be submitted)** If diagnosis is chronic non-malignant pain the patient must have: • A treatment plan that includes a diagnosis & goals of therapy; **AND** • An addiction risk assessment with the therapy (documentation required); **AND** • Attestation from prescriber that Virginia's Prescription Monitoring Program (PMP) database has been recently reviewed; **AND** • A pain management contract that addresses the following: o The consequences of unexplained loss or shortage of drugs, o The consequences of obtaining similar prescription drugs from other prescribers, o Member agrees to use only one pharmacy. o Member agrees to and under goes a random presumptive urine drug screen at least annually or if prescriptions change as part of the treatment plan. A daily dose limit has been established for each LAN. The list can be found at : Daily dose limits LAN & SAN **Additional PDL edit** • Approval of non-preferred agents in this class requires: o Contraindication to PDL preferred agents; **OR** o Drug to drug interaction to PDL preferred agents; **OR** o History of toxic side effects from PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance). Long Acting Narcotic SA Fax Form ****Clinical Criteria for Methadone** All methadone products receive a clinical edit to determine reason for use. Low dose strengths are generally used for pain. Please see criteria for clinical edit for methadone 40 mg dispersible tablets and 10 mg/mL oral concentrated solution for detoxification and maintenance treatment of narcotic addiction.

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Narcotics – Short Acting			
	***Transmucosal Immediate Release Fentanyl**		**LENGTH OF AUTHORIZATIONS:** 3 months **Routine PDL edit plus** ***Clinical Criteria for Transmucosal Immediate Release Fentanyl** • Diagnosis of breakthrough cancer pain; **AND** • Patient is receiving around-the-clock scheduled long-acting narcotics; **AND** • Patient is receiving and tolerant to other opioids as indicated by one of the following: o At least 60 mg of morphine per day for at least one week without adequate pain relief; **OR** o At least 25 mcg/hr of transdermal fentanyl for at least one week without adequate pain relief; **OR** o At least 30 mg oxycodone per day for at least one week without adequate pain relief; **OR** o At least 8 mg hydromorphone per day for at least one week without adequate pain relief; **OR** o An equianalgesic dose of another opioid for at least one week without adequate pain relief; **AND** • Patient has tried and failed at least two immediate release opioid products (e.g., oxycodone, immediate-release morphine, hydromorphone) for breakthrough pain OR has a contraindication, intolerance, or drug-to-drug interaction with at least two immediate release opioid products; **AND** • Patient is 18 years of age or older (16 years of age for Actiq®); **AND** • Must be enrolled in the TIRF REMS ACCESS **Transmucosal Immediate Release Fentanyl SA Fax Form**
		Actiq® *Fentora®* *fentanyl citrate* *Lazanda®* *Subsys®*	
	Opioid Dependency - Methadone Products		***Clinical Criteria for Methadone used for Opioid Dependency** • FDA approved ONLY for detoxification and maintenance treatment of narcotic addiction; **AND** • Patient must be enrolled in a methadone (or opioid) treatment program; **AND** • Dispensed only by opioid treatment programs certified by the Federal Substance Abuse and Mental Health Services Administration and registered by the Drug Enforcement Administration (DEA). **Methadone SA Fax Form**
		***Diskets® 40 mg* **methadone 10 mg/mL intensol oral conc soln* **methadone 40 mg* **Methadose®10 mg/mL oral concentrated soln* **Methadose®40 mg*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Opioid Dependency - Buprenorphine & naltrexone products		**Clinical Criteria for Initiation and Maintenance of Buprenorphine Treatment in Opioid Use Disorder
	**buprenorphine SL **Suboxone® film naloxone syringe & vial naltrexone tab Narcan® Nasal Spray	**Bunavail™ **buprenorphine/naloxone tab Evzio® **Zubsolv™	Buprenorphine FAX form is required • Initial Authorization: 3 months. Additional prior authorizations will not be required for dose adjustments. After 3 months, the provider must submit the SA Request Form for buprenorphine maintenance. • Maintenance authorization: The second and subsequent requests will be authorized for 6 months. Criteria For Initial & Maintenance Authorization 1. All of the following conditions must be met: • Individual has a diagnosis of Opioid Use Disorder; AND • Individual is 16 years of age or older; AND • Prescriber's personal DEA and X DEA Number are provided; AND • Individual is participating in psychosocial counseling (individual or group) at least once per week during first 3 months of initiation. Then at least once per month during maintenance; Plus 2. Buprenorphine monotherapy will only be covered for pregnant women for a maximum of 9 months 3. Maximum of 16 mg per day will be covered unless compelling clinical rationale for exceeding this dose with written documentation is provided. Doses greater than 24 mg per day will not be approved 4. Lock in Policy: the patient is locked in for buprenorphine products to the requesting physician and to the dispensing pharmacy. 5. Concurrent Drugs: The following drugs will NOT be allowed to be prescribed or taken concurrently: tramadol (Ultram®), carisoprodol (Soma®), other opiates, or stimulants. 6. Benzodiazepines will only be allowed for the first three months of treatment. The same provider must prescribe the benzodiazepines & buprenorphine products, and must counsel patient on higher risk of fatal overdose. Maximum daily dose equivalent of clonazepam (Klonopin®) 2 mg will be allowed. Patient must be weaned off benzodiazepines to other anti-anxiety drugs (such as SSRIs, buspirone, or clonidine) by 3 months in order to receive approval of buprenorphine products for maintenance.

	Preferred Agents	Non-Preferred Agents	SA Criteria
			7. During maintenance the prescriber must checking random urine drug screens at least 4 times per 6 months. • Checking for buprenorphine/norbuprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates. • The last 2 urine drug screens (with at least 1 of these screenings within past month). Must be submitted with the 1st maintenance request and each successive request. Quantity Limits BunavailTM 2.1-0.3mg buccal film 34 / 34 days BunavailTM 4.2-0.7mg buccal film 68 / 34 days BunavailTM 6.3-1mg buccal film 68 / 34 days buprenorphine/naloxone 2mg 102 / 34 days buprenorphine/naloxone tablets 8mg 68 / 34 days buprenorphine tablets 2mg 102 / 34 days buprenorphine tablets 8mg 68 / 34 days Suboxone® SL film 2mg 102 / 34 days Suboxone® SL film 4mg 68 / 34 days Suboxone® SL film 8mg 68 / 34 days Suboxone® SL film 12mg 68 / 34 days ZubsolvTM 68 / 34 days Oral Buprenorphine SA Form
	***Short-Acting Narcotics**		Routine PDL edit plus
	codeine/APAP **codeine/APAP/caff/butal**	*All Brands require a SA* *Abstral®*	***Clinical Criteria for Short Acting Narcotics (SAN)**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	codeine/ASA **hydrocodone/APAP** **hydrocodone/ibuprofen** **hydromorphone** **morphine IR** **nalbuphine** **oxycodone IR** **oxycodone/APAP** **tramadol HCL**	*codeine tab/soln* *butalbital comp with codeine* *butorphanol tartrate nasal* *dihydrocodeine/APAP/caffeine* *dihydrocodeine/ASA/caffeine* *hydromorphone liq/supp* *meperidine tab* *Nucynta®* *Oxayd®* *oxycodone/ASA* *oxycodone/ibuprofen* *oxymorphone HCl* *pentazocine/naloxone* *PrimLev™* *Tivorbex®* *tramadol HCL/APAP* *Ultracet®* *Ultram®* Zamicet ®soln	SAN will be limited to a 10 day supply. Prescribers must complete the SAN fax form for quantities that exceed 10 days. Also a daily dose limit has been established for each SAN. The list can be found at: Daily dose limits LAN & SAN **LENGTH OF AUTHORIZATIONS**: • Up to 3 months for chronic malignant pain, post-surgical pain, other acute short term reason; OR • Up to one year for active cancer pain, palliative care, end-of-life care, or sickle cell pain for break through pain relief. Individual must be on a LAN also. **Following CDC Guidelines for Opioid use the following are required;** • A treatment plan that includes a diagnosis & goals of therapy; **AND** • An addiction risk assessment with the therapy (documentation required); **AND** • Attestation from prescriber that Virginia's Prescription Monitoring Program (PMP) database has been recently reviewed; and will be reviewed throughout the course of therapy and with each new prescription; **AND** • A pain management contract has been signed that addresses the following: o The consequences of unexplained loss or shortage of drugs, o The consequences of obtaining similar prescription drugs from other prescribers, o Patient agrees to use only one pharmacy. o Member agrees to a quantitative random urine drug testing at least annually or if prescriptions change as part of the treatment plan. • Approval of non-preferred agents in this class requires: o Contraindication to all PDL preferred agents; **OR** o Drug to drug interaction to all PDL preferred agents; **OR** o History of toxic side effects from all PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance). **Short Acting Narcotic SA Fax Form**

Preferred Agents	Non-Preferred Agents	SA Criteria
Non-Steroidal Anti-Inflammatory Drugs		
Oral		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edit plus** A one-month trial of at least <u>two preferred drugs within the same class.</u> ***Step edit required for Celebrex and celecoxib** • History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year**; OR** • Concurrent use of anticoagulants (i.e., warfarin, heparin, etc.)**,** methotrexate, oral corticosteroids; **OR** • History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.); **OR** • Specific indication for Celebrex®, which preferred drugs are not indicated.
Children's ibuprofen susp (OTC) **ibuprofen (OTC & RX)** **Infant's ibuprofen drops susp (OTC)** **meloxicam tab** **naproxen** **sulindac**	*Anaprox® IR & DS®* *Advil®* *Aleve®* *Arthrotec®* *Cataflam®* **Celebrex®* **celecoxib* *Daypro®* *diclofenac potassium* *diclofenac sodium SR* *diclofenac sodium/misoprostol* *diflunisal* *Duexis®* *etodolac IR & SR* *Feldene®* *fenoprofen* *flurbiprofen* *ibuprofen tab chew OTC* *Indocin®supp* *indomethacin IR, SR & rectal* *ketoprofen IR & ER* *ketorolac* *meclofenamate* *mefenamic* *meloxicam susp* *Mobic®* *Motrin®* *nabumetone* *Nalfon®* *Naprelan®* *Naprosyn®* *naproxen CR (generic Naprelan®)* *naproxen EC* *naproxen sodium* *oxaprozin*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		piroxicam *Ponstel®* *Prevacid Naprapac®* *Sprix® nasal spray* *Tivorbex™* *tolmetin sodium* *Vimovo®* *Vivlodex™* *Voltaren® XR* *Zipsor®* *Zorvolex™*	****Flector®, Voltaren® & Pennsaid®:** • Approval is based on patient failing the oral generic of the desired product and at least one other preferred NSAID (to equal a total of at least two preferred). For example, a patient who failed ibuprofen or naproxen will still need to try oral diclofenac for approval of Flector®. • Pennsaid® can only be approved for the FDA approved indication of osteoarthritis of the knee. • Quantity limit for Flector® = 30 patches per RX.
	Topical		
	****Flector® patch** ****Voltaren® gel (1%)**	***diclofenac sodium 1 % gel* ****diclofenac sodium 3 % gel* ***Pennsaid® top soln & pump* ****Solaraze 3% top gel*	*****Solaraze® 3% & Diclofenac Sodium 3 % Clinical Criteria**: Indicated for the topical treatment of actinic keratosis
Antibiotic-Anti-Infective			
	***Antibiotics, Inhaled**		
	****Tobi Podhaler®** **Bethkis® 300 mg/4 mL** **Kitabis™ Pak 300 mg/5mL**	*Cayston®* *Tobi® inhalation neb soln 300 mg/5 mL* *tobramycin inhalation neb soln 300 mg/5ml (generic Tobi® inhalation)* *tobramycin Pak (generic Kitabis™ Pak)*	**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edit plus** *Minimum age for use is 6 years for all tobramycin inhalation nebulizer solution (Bethkis®, Kitabis™ Pak, Tobi® and Tobi Podhaler®) and 7 years for Cayston®. **Tobi Podhaler® requires a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used (Bethkis® or Kitabis™). **Quantity Limits:** Bethkis® = 224mL (56 amps) /28 days / 28 days Cayston® = 84 mL / 28 days Kitabis™ Pak = 280mL (56 amps) /28 days Tobi Podhaler® = 224 capsule / 28 day Tobi® inhalation *neb* = 280mL (56 amps) /28 days tobramycin = 280mL (56 amps) /28 days

Preferred Agents	Non-Preferred Agents	SA Criteria
Antifungals, Oral		
fluconazole tab/susp **Griseofulvin ® susp** **griseofulvin ultramicrosize** **nystatin tab/susp** **terbinafine**	**Ancobon ®* *clotrimazole (mucous mem)* ***Cresemba®* *Diflucan® tab/susp* *flucytosine* *Grifulvin V® tab* *Gris-Peg®* *griseofulvin tab* *itraconazole* *ketoconazole* ****Lamisil ® tab/granules* *****Noxafil®* ******Onmel®* *******Sporanox® cap/soln* *Terbinex™ kit* ********Vfend® tab/susp* *voriconazole tab & powder for susp*	**LENGTH OF AUTHORIZATIONS**: Duration of the prescription (up to 12 months) **Routine PDL edit plus** **Clinical Criteria for Antifungals, Oral** ***Ancobon®:** • Indicated for the treatment of : ○ **Candida:** septicemia, endocarditis, and UTIs; **OR** ○ **Cryptococcus:** meningitis, pulmonary infections; **OR** • Can be approved if the patient is immunocompromised (i.e. AIDS, cancer, organ transplants). ****Cresemba®** • Indication is treatment of invasive aspergillosis or mucormycosis; **AN**D • Member must be over 18 years of age *****Lamisil® granules** • Indication is tinea capitis; **AND** • Member must be over 4 years of age. ******Noxafil®** • One of the following indications: ○ Used for preventative (prophylactic) therapy for treatment of invasive Aspergillus; **OR** ○ Diagnosis of Candida; **OR** ○ Patient is immunocompromised; **OR** ○ Diagnosis of graft-versus-host disease (GVHD); **OR** ○ Patient has a hematologic malignancy (a cancer of the blood, bone marrow, or lymph nodes); **OR** ○ Patient has prolonged neutropenia from chemotherapy; **OR** ○ Diagnosis of Zygomycosis; **OR** ○ Diagnosis of Fusariosis; **OR** ○ Patient has another fungal infection or mold infection is refractory or resistant to itraconazole or voriconazole, or patient has a contraindication to itraconazole or voriconazole. *******Onmel®** • Indicated for the treatment of onychomycosis of the toenail caused by *Trichophyton rubrum* or *T. mentagrophytes*; **AND**

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• Patient had a therapeutic trial and treatment failure with oral terbinafine; **OR** • Patient has a contraindication to oral terbinafine (i.e. heart failure, hepatic impairment, viral hepatitis). ******Sporanox®** • Indicated for the treatment of Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia. *******Vfend®:** • Can be approved without failure on the preferred agent if the patient has any of the following diagnoses: o Myelodysplastic Syndrome (MDS); **OR** o Neutropenic Acute Myeloid Leukemia (AML); **OR** o Graft versus Host Disease (GVHD); **OR** o Candidemia (candida krusei); **OR** o Esophageal Candidiasis; **OR** o Pulmonary or invasive aspergillosis; **OR** o Blastomycosis; **OR** o Oropharyngeal/esophageal candidiasis refractory to fluconazole, **OR** o Serious fungal infections caused by *Scedosporium apiospermum* (asexual form of *Pseudallescheria boydii*) and *Fusarium* spp., including *Fusarium solani*, in patients intolerant of, or refractory to other therapy, immunocompromised (i.e. AIDS, cancer, organ transplants). **Antifungal Oral SA Fax Form**
	Cephalosporins, Oral		
	Second Generation Cephalosporins		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills. **Routine PDL edit plus** **Clinical Criteria for Cephalosporins** • Infection caused by an organism resistant to preferred drugs, OR • A therapeutic failure to no less than a three-day trial of **one preferred drug within the same class**; **OR** • The patient is completing a course of therapy with a non-preferred drug which was initiated in the hospital.
	cefaclor cap **cefprozil cap/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp* *Ceftin® tab/susp*	
	Third Generation Cephalosporins		
	cefdinir cap/susp **Suprax® susp**	*Cedax® cap/susp* *ceftibuten* *cefixime suspension* *cefditoren pivoxil* *cefpodoxime proxetil cap/susp* *Spectracef®* *Suprax®chewable tab/cap*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Macrolides, Oral		
Macrolides & Ketolides		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edit plus** **Clinical Criteria for Macrolides and Ketolides** • Infection caused by an organism resistant to preferred drugs; **OR** • A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**; **OR** • The patient is completing a course of therapy with a non-preferred drug which was initiated in the hospital. *Generics are not available in some strengths/dosage forms
azithromycin pack/susp/tab **clarithromycin tab/susp** ***E.E.S.®** ***Eryped® 400 susp** **Ery-tab®** **erythromycin base cap DR** **erythrocin stearate** **erythromycin ethylsuccinate** **erythromycin stearate** **erythromycin/sulfisoxazole**	*Biaxin® tab/susp/XL* *clarithromycin ER* ***Eryped® 200 susp*** *erythromycin base tab* *PCE®* *Zithromax® pac/tab/susp* *ZMAX® susp*	
Otic		
Ciprodex®	*Cetraxal®* *Cipro HC®* *ofloxacin*	**LENGTH OF AUTHORIZATIONS:** Date of service only; no refills **Routine PDL edit**
Quinolones, Oral		
Second Generation Quinolones		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edit plus**: **Clinical Criteria for Quinolones** • Infection caused by an organism resistant to preferred drugs; **OR** • A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**; **OR** • The patient is completing a course of therapy with a non-preferred drug which was initiated in the hospital.
ciprofloxacin susp/tab	*Cipro® IR & XR & susp* *ciprofloxacin ER* *Noroxin®* *ofloxacin*	
Third Generation Quinolones		
Avelox® ABC PACK **levofloxacin tab**	*Avelox®* *Levaquin® tab/susp* *levofloxacin susp* *moxifloxacin*	
Topical Antibiotics		
mupirocin ointment	**Altabax™* *Bactroban® cr/ointment* *Centany®* *Centany AT® Kit*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edit** *Quantity Limit = 15 grams per 34 days

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Vaginal Antibiotics		
	Cleocin® Ovules **metronidazole gel**	*Cleocin® cr* *Clindesse ®cr* *clindamycin cr* *Metrogel®* *Nuvessa®* *Vandazole™ gel*	**LENGTH OF AUTHORIZATIONS**: Date of Service **Routine PDL edit**
Antivirals			
	Hepatitis C Agents		

	Interferon		**LENGTH OF AUTHORIZATIONS**: **8 weeks (initial approval for all diagnoses)**
			Routine PDL edit plus
			
			***Clinical Criteria for Direct-Acting Antivirals (DAAs)**
			• All requests will be reviewed for FDA approved label indications and guidelines; **AND**
			• Patient must be 18 years of age or older; **AND**
			• Prescriber must be a gastroenterologist, hepatologist, infectious disease specialist or transplant specialist or in consultation with one of the above; **AND**
			• A baseline HCV-RNA (within 4 weeks of request) must be obtained before treatment initiation. At TW4, if the HCV RNA is ≥25 IU/mL, or at any time point thereafter, all treatment should be discontinued; **AND**
			• Patient must be evaluated for current history of substance and alcohol abuse, attested to by the prescribing physician(s); **AND**
			• Patients must be evaluated for decompensated cirrhosis (which is defined as a Child-Pugh score greater than 6 [class B or C]); **AND**
			• Patients must be evaluated for severe renal impairment (eGFR <30 mL/min/1.73m^2) or end stage renal disease (ESRD) requiring hemodialysis; **AND**
			• Patient must have documentation of Disease Severity (Metavir Score F2 – F4) and/or at high risk of disease progression. In addition, documentation of a Metavir Score will not be required if a patient;
			  • has a comorbid diseases including HIV, hepatitis B or serious extra hepatic manifestations such as cryoglobulinemia, membranoproliferative glomerulnephrits: OR
			  • has renal failure, is on dialysis or has a liver transplant; OR

	Peg-Intron® **Peg-Intron Redipen®**	*Pegasys® Proclick/syringe/kit/vial*	
	Protease Inhibitor		
	Victrelis®	*Olysio™*	
	***Nucleotide Analog NS5A & NS5B Polymerase Inhibitors**		
	Daklinza® (Genotype 3)	*Sovaldi®*	
	***NS5A, NS3/4A Inhibitor Combinations**		
	Technivie™ **Viekira Pak™**	**Zepatier™**	
	***NS5B & Protease Inhibitor combinations**		
		Harvoni®	

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• is diagnosed with Genotype 3 hepatitis C **Renewal Criteria** • Patient is compliant with drug therapy regimen (per pharmacy paid claims history); **AND** • Drug is prescribed in accordance to FDA approved label indications and guidelines **Hepatitis C Antivirals SA Fax Form**
	Herpes Oral		
	acyclovir tab **famciclovir** **valacyclovir** **Zovirax® susp**	*acyclovir susp* *Famvir®* *Sitavig® buccal tab* *Valtrex®* *Zovirax® tab/susp*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Herpes Topical		
	Abreva OTC® **Zovirax® cr**	*acyclovir oint* *Denavir®* *Xerese® cr* *Zovirax® oint*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Influenza		
	amantadine tab/syrup **Relenza Disk®** **rimantadine** **Tamiflu® cap/susp**	*amantadine cap* *Flumadine® tab*	**LENGTH OF AUTHORIZATIONS:** Date of service only **Routine PDL edit**
Blood Modifiers			
	Bile Salts		
	ursodiol 300 mg cap	*Actigal®* *Chenodal®* *Cholbam®* *ursodiol tab* *Urso®* *Urso® Forte tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Phosphate Binders		
	calcium acetate 667mg cap **Fosrenol®** **Renagel®** **Renvela® tablet**	*Auryxia™* *calcium acetate 667mg tab* *Eliphos®* *Ferric citrate* *Fosrenol® Powder Pack* *Phoslo®* *Phoslyra®* *Renvela® powder* *sevelamer carbonate* *Velphoro® chewable tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Bone Resorption Suppression and Related Agents			
	Bisphosphonates		
	alendronate tab	*Actonel®* *alendronate soln* *Atelvia DR®* *Boniva®* *Binosto™* *etidronate* *Fosamax®tab* *Fosamax® plus D* *ibandronate* *risedronate DR*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit** Bisphosphonates are indicated only for treatment of Paget's disease of bone OR the prevention and treatment of heterotopic ossification following total hip replacement or spinal cord injury.
	Calcitonins		
	Fortical®	*calcitonin-salmon nasal* *Miacalcin®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Others		
	raloxifene	*Evista®* **Forteo®*	**LENGTH OF AUTHORIZATIONS**: Initial approval will be for 1 year **Routine PDL edit plus** ***Clinical Critieria for Forteo® (teriparatide)**

	Preferred Agents	Non-Preferred Agents	SA Criteria

			• Treatment of osteoporosis in postmenopausal women who are at high risk for fracture; **OR**
			• Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures; **OR**
			• Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture; **OR**
			• Bone mineral density of -3 or worse; **OR**
			• Postmenopausal women with history of non-traumatic fracture(s); **OR**
			• Postmenopausal women with two or more of the following clinical risk factors:
			  ○ Family history of non-traumatic fracture(s); **OR**
			  ○ Patient history of non-traumatic fracture(s); **OR**
			  ○ DXA BMD T-score ≤-2.5 at any site; **OR**
			  ○ Glucocorticoid use* (≥6 months of use at 7.5 dose of prednisolone equivalent); **OR**
			  ○ Rheumatoid Arthritis; **OR**
			  ○ Postmenopausal women with BMD T-score ≤-2.5 at any site with any of the following clinical risk factors:
			  ▪ More than 2 units of alcohol per day; **OR**
			  ▪ Current smoker; **OR**
			  ▪ Men w/primary or hypogonadal osteoporosis; **OR**
			  ▪ Osteoporosis associated w/sustained systemic glucocorticoid therapy.
			* Maximum duration of therapy is 24 months during a patient's lifetime for Forteo®
			Forteo® SA Fax Form

Cardiac

Anticoagulants

Low Molecular Weight Heparin includes FactorXA Inhibitor		
enoxaparin	*Arixtra®* *fondaparinux* *Fragmin® syringe & vial* *Lovenox®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus**

Preferred Agents	Non-Preferred Agents	SA Criteria
Oral Anticoagulants		**Clinical Criteria for Anticoagulant, Oral**
warfarin ***Pradaxa®** *****Xarelto®**	*Coumadin®* **Eliquis™* ***SavaysaTM* *****Xarelto Starter Pack*	***Eliquis™** • May be approved for the following: ○ Reduction in risk of stroke and systemic embolism in non-valvular atrial fibrillation; **OR** ○ Prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in patients who have undergone hip or knee replacement surgery; **OR** ○ Treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE following initial therapy. ****Pradaxa®** • May be approved for the following: ○ To reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation; **OR** ○ Treatment of deep venous thrombosis (DVT) OR pulmonary embolism (PE) in patients who have been treated with a Parenteral anticoagulant for 5-10 days; **OR** ○ To reduce the risk of recurrence of DVT and PE in patients who have been previously treated. ○ Prophylaxis of DVT and PE following hip replacement surgery ***Savaysa™** • May be approved for the following: ○ To reduce the risk of stroke and systemic embolism in non-valvular atrial fibrillation; **OR** ○ Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of initial therapy with a parenteral anticoagulant. ****** Xarelto® (rivaroxaban)** • May be approved for the following: ○ To reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation; **OR** ○ Treatment of deep vein thrombosis (DVT), pulmonary embolism,(PE), and for the reduction in the risk of recurrence of DVT and of PE; **OR** ○ Prophylaxis of DVT, which may lead to PE in patients undergoing knee or hip replacement surgery **Oral Anticoagulants SA Fax Form**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antihypertensive Agents		
ACE Inhibitors		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edit**
benazepril **captopril** **enalapril** **lisinopril** **ramipril**	*Accupril®* *Altace®* *Epaned™ soln* *fosinopril* *Lotensin®* *Mavik®* *moexipril* *Monopril®* *perindopril* *Prinivil®* *quinapril* *ramipril* *trandolapril* *Univasc®* *Vasotec®* *Zestril®*	
ACE Inhibitors + Calcium Channel Blocker Combinations		
amlodipine/benazepril	*Lotrel®* *Tarka®* *trandolapril-verapamil ER*	
ACE Inhibitors + Diuretic Combinations		
benazepril/HCTZ **lisinopril/HCTZ**	*Accuretic®* *captopril/HCTZ* *enalapril/HCTZ* *fosinopril/HCTZ* *Lotensin HCT®* *moexipril/HCTZ* *quinapril/HCTZ* *Vaseretic®* *Zestoretic®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Angiotensin Receptor Blockers		***Clinical Criteria for Entresto™** • Diagnosis of chronic heart failure (NYHA Class II-IV); **AND** • Patient must be ≥ 18 years; **AND** • Left ventricular ejection fraction ≤ 40% Quantity Limit = 2 per day for Entresto™
Diovan® ***Entresto™** **losartan**	*Atacand®* *Avapro®* *Benicar®* *candesartan* *Cozaar®* *Edarbi®* *eprosartan mesylate* *irbesartan* *Micardis®* *telmisartan/HCTZ* *Teveten®* *Valsartan*	
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations		
	Azor® *amlodipine/valsartan/HCTZ (generic for Exforge®HCT)* *amlodipine/valsartan (generic for Exforge®)* *Exforge® & Exforge®HCT* *Tribenzor®*	
Angiotensin Receptor Blockers + Diuretic Combinations		
losartan/HCTZ **valsartan/HCTZ**	*Atacand HCT®* *Avalide®* *Benicar HCT®* *candesartan/HCTZ* *Diovan HCT®* *Edarbyclor®* *Hyzaar®* *irbesartan/HCTZ* *Micardis HCT®* *Teveten HCT®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Antihypertensives, Sympatholytics		**Clinical Criteria for Antihypertensives, Sympatholytics** • A therapeutic failure of at least two preferred drug(s) within the same class.
Catapres®-TTS **clonidine tab** **guanfacine** **methyldopa** **reserpine**	*Catapres®* *clonidine (transdermal)* *Clorpres®* *methyldopa/HCTZ* *Tenex®*	
Beta Blockers		***Clinical Criteria for Hemangeol™** • Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy; **AND** • Patient's age must be between 5weeks and 5 months.
atenolol **carvedilol** **labetalol** **metoprolol tartrate** **nadolol** **propranolol tab/soln** **Sorine®** **sotalol AF** **sotalol HCL**	*acebutaolol* *Betapace® IR & AF®* *betaxolol* *bisoprolol* *Bystolic®* *Coreg® IR & CR®* *Corgard®* **Hemangeol™* *Inderal® XL* *Innopran® XL* *Levatol®* *Lopressor®* *metoprolol succinate* *pindolol* *propranolol LA* *Sectral®* *Sotylize™* *Tenormin®* *timolol maleate* *Toprol XL®* *Trandate®* *Zebeta®*	
Beta Blockers + Diuretic Combinations		
atenolol/ chlorthalidone **bisoprolol/HCTZ** **nadolol/bendroflumethiazide** **propranolol/HCTZ**	*Corzide®* *Dutoprol®* *Lopressor HCT®* *metoprolol/HCTZ* *Tenoretic®* *Ziac®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Calcium Channel Blockers -Dihydropyridine		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Afeditab CR® **amlodipine** **Nifedical XL®** **nifedipine** **nifedipine ER**	*Adalat CC®* *felodipine ER* *isradipine* *nisoldipine* *nicardipine* *Norvasc®* *Procardia®* *Procardia XL®* *Sular®*	
Calcium Channel Blockers- Non-Dihydropyridine		
Cartia XT® **diltiazem IR, ER q 12 hr & 24 hr** **Taztia XT®** **verapamil tab IR & ER**	*Calan® IR & SR* *Cardizem® IR, CD & LA* *Isoptin SR®* *Matzim LA* *Tiazac®* *verapamil ER cap* *Verelan® & Verelan PM®*	
Direct Renin Inhibitors (includes combination)		
	Tekamlo® *Tekturna®* *Tekturna HCT®* *Twynsta®* *telmisartan/amlodipine*	
Lipotropics		
Bile Acid Sequestrants		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** Therapeutic failure to no less **than three-month trial of at least one preferred drug**.
cholestyramine powder reg & light **colestipol tab** **Prevalite®** **Welchol ® tab**	*Colestid® granule/packet/tab* *colestipol HCl granules* *Questran® powder/powder Light* *Welchol® packet*	
Cholesterol Absorption Inhibitor (CAI)		
Zetia®		

Preferred Agents	Non-Preferred Agents	SA Criteria
Fibric Acid Derivatives		
gemfibrozil **Tricor®**	*Antara®* *fenofibrate (generic for Antara®)* *fenofibrate(generic Fenoglide®)* *fenofibrate (generic for Lipofen®)* *fenofibrate (generic Tricor®)* *fenofibric acid* *Fenoglide®* *Fibricor®* *Lipofen®* *Lofibra®* *Lopid®* *Triglide®* *Trilipix™*	
HMG CoA Reductase Inhibitors and Combo (High Potency Statins)		
atorvastatin **simvastatin**	*amlodipine/atorvastatin* *Caduet®* *Crestor®* *Lipitor®* *Liptruzet®* *Livalo®* *Vytorin®* *Zocor®*	
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin **pravastatin**	*Advicor®* *Altoprev®* *fluvastatin* *Lescol®* *Lescol XL®* *Mevacor®* *Pravachol®*	
Microsomal Triglyceride Transfer Protein Inhibitor		**Clinical Criteria for Lipotropics, Other**
	**Juxtapid ™*	***Juxtapid™** • Diagnosis of homozygous familial hypercholesterolemia (HoFH); **AND**

Preferred Agents	Non-Preferred Agents	SA Criteria
		• Prescriber must be certified with the Juxtapid™ REMS program; **AND** • Minimum age restriction of 18 years of age; **AND** • Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants. **Juxtapid™ SA Fax Form**
Niacin Derivatives		
Niaspan®	*niacin ER* *Niacor®*	
Niacin Derivatives & HMG CoA Reductase Inhibitors Combo		**Simcor®**
	**Simcor®*	• Step edit requires a history of either a niacin or simvastatin product within the past 365 days
Omega 3 Fatty Acid Agent		
	****Lovaza®* ****omega-3 acid ethyl esters* *Vascepa®*	*****Lovaza®** • Step edit requires trial and failure of any other lipotropic; **OR** • Documented high triglycerides of ≥ 500 mg/dL.
Oligonucleotide Inhibitor		
	*****Kynamro™*	******Kynamro™** • Diagnosis of homozygous familial hypercholesterolemia (HoFH); **AND** • Prescriber must be certified with the Kynamro™ REMS program; **AND** • Patient must be at least 18 years of age; **AND** • Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants. **Kynamro™ SA Fax Form**
Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors		**LENGTH OF AUTHORIZATIONS**: Three months for initial approval; six months for renewal **Clinical Criteria for PCSK9** *******Praluent®** **Initial Criteria** • Patient is ≥ 18 years of age; **AND** • Prescribed by or in consultation with a specialist (including cardiologists, lipidologists, or endocrinologists); **AND** • Diagnosis of atherosclerotic cardiovascular disease (ASCVD); **AND**
	******Praluent® pens/syringes* *******Repatha Sureclick & syringes*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			• Heterozygous familial hypercholesterolemia (HeFH) as confirmed by genotyping or by clinical criteria ("definite FH" using either the Simon Broome or WHO/Dutch Lipid Network criteria); **AND** • Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND ezetimibe for at least three continuous months with failure to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patients with HeFH and no history of clinical ASCVD) • If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following: o Muscle symptoms resolve after discontinuation of statin; **AND** o Muscle symptoms occurred when re-challenged at a lower dose of the same statin; **AND** o Muscle symptoms occurred after switching to an alternative statin; **AND** o Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease); **OR** o The patient has been diagnosed with statin-induced rhabdomyolysis • The diagnosis should be supported by acute neuromuscular illness or dark urine AND an acute elevation in creatine kinase (usually >5,000 IU/L or five times the upper limit of normal) • If the patient failed to reach target LDL-C (<70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with HeFH and no history of clinical ASCVD), adherence to maximally-tolerated statin and ezetimibe has been verified using pharmacy claims data and the patient is determined to be compliant for at least three consecutive months prior to the lipid panel demonstrating suboptimal reduction • Maximally-tolerated statin will continue to be used in conjunction with alirocumab; **AND** • Patient has not had a prior trial and failure of an alternative PCSK9 inhibitor; **AND** • Request is being made for the lowest approved alirocumab dose (75 mg every 2 weeks) to adequately treat the patient. Requests for an escalated dose (150 mg

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*

			every 2 weeks) must contain a lipid panel documenting suboptimal reduction in LDL-C after at least 4 weeks (2 doses) of alirocumab at the lower (75 mg every 2 weeks) dose.
			
			Renewal Criteria (may be requested by PCP)
			• Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating alirocumab; **AND**
			• Continued adherence to maximally-tolerated statin dose established prior to the original alirocumab approval
			
			Quantity Limit
			• Two pens/syringes per month
			
			******Clinical Criteria for Evolocumab (Repatha™) Criteria**
			LENGTH OF AUTHORIZATIONS: Three months for initial approval; six months for renewal
			
			INITIAL CRITERIA
			• Age ≥ 18 years if diagnosis is
			  ○ atherosclerotic cardiovascular disease (ASCVD); **AND**
			  ○ heterozygous familial hypercholesterolemia (HeFH):**OR**
			• Age ≥ 13 years if diagnosed with homozygous familial hypercholesterolemia (HoFH); **AND**
			• Prescribed by or in consultation with a specialist (including cardiologists, lipidologists, or endocrinologists); **AND**
			• Diagnosis of ASCVD, HeFH as confirmed by genotyping or by clinical criteria ("definite FH" using either the Simon Broome or WHO/Dutch Lipid Network criteria), or HoFH as confirmed by either:
			  ○ Documented DNA test for functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality **OR**
			  ○ A history of an untreated LDL-C concentration > 500 mg/dL and triglycerides <300 mg/dL and both parents with documented untreated TC >250 mg/dL; **AND**
			• Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND ezetimibe for at least three continuous months with failure to reach target LDL-C (70 mg/dL for

	Preferred Agents	Non-Preferred Agents	SA Criteria
			patients with clinical ASCVD and 100 mg/dL for patients with HeFH or HoFH and no history of clinical ASCVD) • If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following: o Muscle symptoms resolve after discontinuation of statin; **AND** o Muscle symptoms occurred when re-challenged at a lower dose of the same statin; **AND** o Muscle symptoms occurred after switching to an alternative statin; AND o Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease); **OR** • The patient has been diagnosed with statin-induced rhabdomyolysis o The diagnosis should be supported by acute neuromuscular illness or dark urine; **AND** o an acute elevation in creatine kinase (usually >5,000 IU/L or five times the upper limit of normal). • If the patient failed to reach target LDL-C (<70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with HeFH or HoFH and no history of clinical ASCVD), adherence to maximally-tolerated statin and ezetimibe has been verified using pharmacy claims data and the patient is determined to be compliant for at least three consecutive months prior to the lipid panel demonstrating suboptimal reduction. • Maximally-tolerated statin will continue to be used in conjunction with evolocumab: **AND** • Patient has not had a prior trial and failure of an alternative PCSK9 inhibitor. **Renewal Criteria (May be requested by PCP)** • Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating evolocumab; **AND** • Continued adherence to maximally-tolerated statin dose established prior to the original evolocumab approval. **Quantity Limit** • ASCVD or HeFH: Two pens or syringes per month

Preferred Agents	Non-Preferred Agents	SA Criteria
		• HoFH: Three pens or syringes per month
Platelet Inhibitors		
clopidogrel **dipyridamole** **Effient®** **ticlopidine HCL**	*Aggrenox®* *ASA/dipyridamole* *Brilinta®* **Durlaza ER™* *Persantine®* *Plavix®* ***Zontivity™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** **Clinical Criteria for Platelet Inhibitors** ***Durlaza ER™** • Aspirin is covered without SA; clinical reason as to why aspirin cannot be used. **** Zontivity™** • Diagnosis of MI (myocardial infarction) or PAD (peripheral arterial disease); **AND** • Patients must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer; **AND** • Must have concomitant therapy with clopidogrel, unless patient has a contraindication to clopidogrel in which case patient must have concomitant therapy with aspirin; **AND** • Patient is 18 years of age or older; **AND** • Prescribed by or in consultation with a cardiologist.
Pulmonary Arterial Hypertension Agents		
Inhaled Prostacyclin Analogues		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Tyvaso® **Ventavis®**		
Oral Endothelin Receptor Antagonist		
Letairis® **Tracleer®**	*Opsumit®*	
***Phosphodiesterase 5 Inhibitors (PDE-5)**		***Clinical Criteria for PDE-5**
sildenafil tab	*Adcirca™* *Revatio® tab,susp & inj*	• Diagnosis of pulmonary hypertension in patients >18 years is required; **AND** • The prescriber must be a pulmonary specialist or cardiologist; **AND** • Must have a rationale for not taking the oral Revatio® to receive a SA for the injectable Revatio®.

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Prostacyclin Vasodilator and Receptor Agonist		
		Orenitram™ Uptravi®	
	Solnble Guanylate Cyclase Stimulators		
		Adempas®	
Central Nervous System			
	Alzheimer's Agents		
	Cholinesterase Inhibitors		**LENGTH OF AUTHORIZATIONS**: Length of prescription (up to 3 months) **Routine PDL edit**
	donepezil tab **Exelon® (transderm)**	*Aricept® ODT, tab & 23 mg tab* *donepezil ODT & 23mg tab* *Exelon® cap* *galantamine IR, ER tab/soln* *Razadyne® IR, ER* *rivastigmine cap & patch* *Namzaric®* **(***donepezil/memantine)*	
	NMDA Receptor Antagonist		
	Namenda® soln **memantine tab**	*Namenda® Dose Pack /XR tab* *Namenda® tab* *memantine Dose Pack &* soln	
	***Anticonvulsants**		
	Barbiturates		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edit plus** ***Clinical Criteria for Anticonvulsants**: • A therapeutic failure of at least one preferred drugs within the same class.
	phenobarbital elixir/ tab **primidone**	*Mysoline®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Benzodiazepines		
clonazepam **Diastat® rectal** **Diastat® AcuDial™ rectal**	*clonazepam ODT* *diazepam® rectal* *diazepam® Device rectal* *Fin® tab* *Onfi ®susp/tab*	**Onfi SA Fax Form**
Carbamazepine Derivatives		
carbamazepine chewable tab/susp/tab **carbamazepine ER (generic for Carbatrol®)** **oxcarbazepine tab** **Tegretol®XR** **Trileptal® susp**	*Aptiom®* *carbamazepine XR* *Carbatrol®* *Equetro® cap* *oxcarbazepine susp* *Oxtellar™ XR* *Tegretol® susp/tab* *Trileptal®* tab	
Hydantoins		
Dilantin® cap/Infatab **phenytoin cap/ chew tab /susp/** **phenytoin ext cap** **Phenytek®**	*Dilantin® susp* *Peganone®*	
Succinimides		
ethosuximide cap/syrup	*Celontin®* *Zarontin® cap/syrup*	
Valproic Acid and Derivatives		
Depakote® sprinkle **divalproex tab** **divalproex ER** **valproic acid**	*Depakene® cap/syrup* *Depakote® ER* *divalproex sprinkle* *Stavzor®*	
Other Anticonvulsants		
felbamate susp/tab **Gabitril®** **Lamictal® XR** **lamotrigine tab** **levetiracetam soln/ tab** **levetiracetam ER** **Vimpat® soln/tab**	*Banzel® susp/tab* *Felbatol® susp/tab* *Fycompa®* *Keppra® soln/tab* *Keppra® XR* *Lamictal® ODT/ODT dose pk* *Lamictal® tab/dose pk*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Topamax® sprinkle **topiramate tab** **zonisamide**	*Lamictal® XR dose pk* *lamotrigine tab dose pk* *lamotrigine ODT* *lamotrigine XR* *Potiga®* *Qudexy ™ XR* *Sabril® powder pack/tab* *tiagabine* *Topamax® tab* *topiramate ER* *topiramate sprinkle* *Trokendi™ XR* *Zonegran®*	

Antidepressants

Other		
bupropion IR, SR &XL **mirtazapine ODT & tab** **trazodone** **venlafaxine IR & ER cap**	*Aplenzin®* *Brintellix®* *desvenlafaxine ER* *desvenlafaxine fumarate ER* *Effexor® XR* *Emsam® transdermal* *Fetzima®* *Forfivo® XL* *Khedezla™* *Marplan®* *Nardil®* *nefazodone* *Oleptro® ER* *Parnate®* *phenelzine* *Pristiq®* *Remeron® ODT & tab* *tranylcypromine sulfate* *venlafaxine ER tab* *Viibryd® tab/dose pk* *Wellbutrin® IR, SR & XL*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edit plus** **Clinical Criteria for Antidepressants** • A therapeutic failure of at **least two preferred drugs within the same class**.

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
SSRI		
citalopram soln/tab **escitalopram tab** **fluoxetine cap/soln** **fluvoxamine** **paroxetine tab** **sertraline tab**	*Brisdelle®* *Celexa® tab* *escitalopram soln* *fluoxetine DR cap/tab* *fluvoxamine ER* *Lexapro® soln/tab* *Luvox® CR* *paroxetine CR* *Paxil® tab/susp & Paxil® CR* *Pexeva®* *Prozac® cap/weekly* *Sarafem®* *sertraline conc* *Zoloft® conc/tab*	
Antimigraine Agents		
Relpax® **sumatriptan succinate** tab **cartridge/nasal/vial/pen** **rizatriptan tab & MLT**	*almotriptan* *Alsuma®* *Amerge®* *Axert®* *Cambia®* *Frova®* *Imitrex®* *cartridge/nasal/pen/tab/vial* *Maxalt®tab &MLT* *naratriptan* *Sumavel® Dosepro* *Treximet®* *Zecuity® patch* *Zomig® tab/nasal spray/ZMT*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edit**

Preferred Agents	Non-Preferred Agents	SA Criteria
Antipsychotics		
Atypical		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edit plus** **Clinical Criteria for Antipsychotics** • A therapeutic failure of at least one preferred drug within the same class. **Antipsychotics In Children Less Than 18 Years SA Fax Form**
Abilify® tab **aripiprazole soln** **clozapine ODT/tab** **Fanapt® tab** **Geodon® IM** **Latuda®** **olanzapine ODT/tab** **olanzapine/ fluoxetine** **quetiapine tab** **risperidone ODT/ soln/tab** **Seroquel® IR/XR** **ziprasidone capsule**	*Abilify® IM* *aripiprazole tab* *aripiprazole ODT* *Clozaril®* *Fanapt® titration pk* *Fazaclo®* *Geodon®* *Invega®* *olanzapine IM* *paliperidone ER* *Rexulti® tab* *Risperdal® ODT/soln/tab* *Saphris® SL* *Symbyax®* *Versacloz™* *Vraylar™* *Zyprexa® tab/IM/Zydis*	
Typical		
amitriptyline/perphenazine **chlorpromazine** **fluphenazine elixir/soln/tab** **haloperidol tab** **haloperidol lactate conc/IM** **loxapine** **perphenazine** **trifluoperazine** **thiothixene** **thioridazine**	*haldol (injection)* *pimozide* *Moban®* *molindone* *Orap®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Neuropathic Pain		
capsaicin OTC topical **duloxetine 20, 30 & 60 mg** **gabapentin cap , tab & soln** **lidocaine 5% patch** **Lyrica® cap**	*Cymbalta®* *duloxetine 40 mg* *Gralise™* *Horizant ™* *Irenka™* *Lidoderm® patch* *Lyrica® Soln* *Neurontin® cap, tab, soln* *Savella™ & Savella™ Dose Pak* *Qutenza Kit® (Topical)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL**
Non-Ergot Dopamine Receptor Agonist		
pramipexole **ropinirole HCl**	*Mirapex® IR & ER* *Neupro®* *pramipexole ER* *Requip® IR & XR* *ropinirole HCl ER*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edit**
Sedatives / Hypnotics		
temazepam 15 & 30 mg	*estazolam* *flurazepam* *Halcion®* *Restoril®* *temazepam 7.5 mg / 22.5 mg* *triazolam*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months) **Routine PDL edit plus**
Sedatives / Hypnotics (Non-Benzodiazepine)		
zolpidem	*Ambien® IR & CR* *Belsomra®* *Edluar™* *eszopiclone* **Hetlioz™* *Intermezzo®* *Lunesta®* *Rozerem®* *Silenor®*	***Clinical Criteria for Hetlioz™** Length of Authorization: 6 months. **For Renewal -** must document therapeutic benefit and confirm compliance • For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24), **AND** • The patient is completely blind, **AND** • Patient must be age 18 years of age or older. • Quantity limit = 1 tablet per day.

Preferred Agents	Non-Preferred Agents	SA Criteria
	Sonata® *Zaleplon®* *zolpidem CR* *Zolpimist ™ spray*	
Skeletal Muscle Relaxants		
baclofen **chlorzoxazone** **cyclobenzaprine HCL** **dantrolene sodium** **methocarbamol** **tizanidine tab**	*Amrix®* ***carisoprodol*** **carisoprodol/ASA* **carisoprodol/ASA/codeine* *cyclobenzaprine ER* *Dantrium®* *Fexmid®* *Lorzone®* *metaxalone* *orphenadrine citrate* *orphenadrine/ASA/caffeine* *Parafon Forte® DSC* *Robaxin®* *Skelaxin®* **Soma®* *tizanidine cap* *Zanaflex®*	**LENGTH OF AUTHORIZATIONS:** • 1 year for chronic conditions • Duration of prescription (up to 3 months) for acute conditions • One month per every 6 months for carisoprodol products **Routine PDL edit plus** ***Clinical Criteria for Carisoprodol Products** • The patient is at least 16 years of age; **AND** • Only approve for ACUTE, painful musculoskeletal conditions. • Quantity limit = 4 tablets per day • Limit approval to one month supply (120 tablets) • Additional authorization will not be granted for at least 6 months following the last day of the previous course of therapy. **Soma/carisoprodol SA Fax Form**
Smoking Cessation		
bupropion SR **Chantix®** **Chantix® DS PK** **nicotine gum/lozenge/patch**	*Nicoderm CQ® Patch* *Nicorette® Gum/Lozenges* *Nicotrol® Inhaler & NS* *Zyban®*	**LENGTH OF AUTHORIZATIONS:** 6 months **Routine PDL edit**
***Stimulants/ADHD Medications**		
Amphetamine Products		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** ***Clinical Criteria for all Stimulants/ADHD Drugs** Age Edits for Stimulants • Patients > 18 years old - a confirmed diagnosis of ADHD, ADD; OR other FDA
****Adderall® XR** **amphetamine salts combo** **dextroamphetamine** **Vyvanse®**	*Adderall® IR* *amphetamine salts combo XR* *Desoxyn®* *Dexedrine®* *dextroamphetamine SR & soln*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Dyanavel™ XR susp *Evekeo™* *methamphetamine* *Procentra® soln* *Zenzedi™*	approved indication is required. • Each product listed below requires an SA for ages less than the FDA/PI indicated age.
Methylphenidate Products		
Focalin XR® **All methylphenidate generic IR tablets** **methylphenidate SR**	*Aptensio ™ XR* *Concerta®* *Daytrana®* *dexmethylphenidate IR & XR* *Focalin®* *Metadate CD®* *Metadate ER®* *Methylin ER®* *Methylin® chew& soln* *methylphenidate chew & soln* *methylphenidate LA* *Ritalin®* *Ritalin LA® & SR®* *QuilliChew ER™* *Quillivant™ XR* susp	

Brand name	PI age less than
Aptensio ™ XR	6 years
Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta® Ritalin LA® etc.	6 years
Dyanavel™ XR susp	6 years
Focalin XR®	6 years
Intuniv®	4 years
Immediate release formulations: e.g.,methylphenidate	3 years
Kapvay® SR	6 years
Strattera®	6 years
QuilliChew ER™	6 years
Quillivant™ XR susp	6 years

**__Step Edit for Adderall XR®__
If a trial & failure of a preferred product occurs and the physician requests Adderall XR® or amphetamine salts combo XR. The brand Adderall XR®- is preferred over the generic.

Stimulants/ADHD Meds in Children Less Than FDA Indicated Age & Over 18 SA Fax Form

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Miscellaneous Products		**Step Edit for**Kapvay® SR 12H** If a trial & failure of a preferred product occurs and the physician requests **Kapvay® SR 12H or** clonidine ER **then Kapvay® SR** is preferred over the generic clonidine ER. *****Nuvigil™/Provigil®/modafinil:**: **Length of Authorizations:** 1 year for sleep apnea and narcolepsy; 6 months for shift work sleep disorder. • Approvable diagnoses include: ○ **Sleep Apnea:** Requires documentation/confirmation via sleep study or that C-PAP has been maximized; **OR** ○ **Narcolepsy:** Documentation of diagnosis via sleep study; **OR** ○ **Shift Work Sleep disorder: ONLY APPROVABLE FOR 6 MONTHS**, work schedule must be verified and documented. Shift work is defined as working the all night shift. • Minimum age of 16 years for Provigil® • Minimum age of 17 years for Nuvigil™
	Strattera® ****Kapvay® SR 12H**	*clonidine ER (generic Kapvay®)* *guanfacine ER* ****modafinil* ****Nuvigil ™* ****Provigil®* *Intuniv®*	

Dermatologic

Acne Agents, Topical

	Combo Benzoyl Peroxide , Clindamycin, Erythromycin Topical		
	benzoyl peroxide wash/cr/gel/lotion (OTC) **Benzaclin®** **Benzaclin® Pump** **clindamycin phosphate sol** **erythromycin solution** **Panoxyl-4 Acne Cr Wash (OTC)**	*Acanya™ w/pump* *Acne Clearing System® (OTC)* *Avar Cleanser, Medicated Pad* *Avar-E* *Avar-E LS* *Avar LS Cleanser, Medicated Pad* *Azelex®* *Benzamycin* *BP 10-1* *Benzefoam™ regualr &Ultra™* *Benzepro* *benzoyl peroxide wash/cr/gel/ lotion/foam/towelette (RX)* *benzoyl peroxide 6% cleanser (OTC)*	LENGTH OF AUTHORIZATIONS: 1 year **Routine PDL edit plus** Failure to respond to a therapeutic trial of at least two weeks of one preferred drug. **Clinical Criteria for Dermatologic Acne Agents** • Prescriptions for patients over the age of 18 years will require a SA to determine diagnosis for treatment; **AND** • Products are intended for acne **only. SA for a cosmetic indication cannot be approved**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		BPO Kit Cleocin T® Clindacin™ Pac Kit Clindagel® clindamycin/benzoyl peroxide (Benzaclin®) & (Duac®) generics clindamycin phosphate foam, gel, lotion, med swab Delos™ Lotion™ Duac® gel erythromycin gel, med. swab Evoclin™ Inova™ Lavoclen™ Cleanser & Kit Neuac™ topical/kit Onexton™ gel & w/Pump Ovace Wash, Ovace Plus Cream ER, Cleanser ER, Lot, Shampoo, Wash Pacnex®HP & LP Panoxyl® 3% cr OTC Promiseb® Complete Rosula Cleanser Se BPO® Wash Kit & cleanser Sulfacetamide Cleanser ER Sulfacetamide Cleanser, Shampoo, Susp Sulfacetamide Sodium/Sulfur Cr, Susp, Sunscreen SSS 10-5 Foam Sulfacetamide/Sulfur/ Cleanser, Cleanser Kit, Lotion Med. Pad, Sulfacetamide / Sulfur / Urea Cleanser Sumadan Wash, Kit Sumadan XLT Sumaxin CP Kit Veltin	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Retinoids/Combinations , Topical		
Differin® 0.1% cr/gel/lot **Differin® 0.3% cr/gel/lot** **Retin®A 0.025., 0.05, 0.1 % cr & 0.01, 0.025,% gel**	Acnefree® Severe Kit Otc *adapalene 0.1% cr/gel/lot* *adapalene 0.3% gel/gel w/pump* *Atralin® 0.05% gel* *Avage® 0.1% cr* *Avita® 0.025% cr/gel* *Epiduo® & Epiduo® Forte Gel* **Fabior™ 01% Foam* *Renova® 0.02% cr/cr pump* *Retin®-A Micro 0.04%, 0.1% gel* *Retin®-A Micro* 0.08%, *0.04%, 0.1% pump* *Tazorac® Cr& gel* *tretinoin 0.025, 0.1% cr & 0.01, 0.025, 0.05% gel* *tretinoin microsphere 0.04% & 0.1% gel* *Ziana® gel*	***Clinical Criteria for Fabior™ Foam** • Patient must be between the ages of 12 and 18 years of age
Antifungal Topical		
ciclopirox soln **clotrimazole cr (RX)** **clotrimazole cr (OTC)** **clotrimazole soln (OTC)** **clotrimazole-betamethasone cr** **ketoconazole shampoo** **ketoconazole cr** **miconazole oint (OTC)** **miconazole nitrate (OTC)** **miconazole powder (OTC)** **miconazole spray (OTC)** **miconazole cr (OTC)** **nystatin oint**	*Alevazol® OTC* *Azolen® Tincture OTC* *Bensal HP®* *Ciclodan® Kit* *ciclopirox cr/shampoo/gel* *ciclopirox kit* *ciclopirox suspension* *clotrimazole solution RX* *clotrimazole-betamethasone lotion* **CNL 8® Kit* *Desenex® Aero Powder (OTC)* *econazole* *Ertaczo®* *Exelderm® cr* *Exelderm® soln* *Extina®*	**LENGTH OF AUTHORIZATIONS: 6 MONTHS** **Routine PDL edit** ***Clinical Criteria for Topical Onychomycosis Agents (ciclopirox/Penlac®, CNL-8™, Jublia®, Kerydin™)** • Patient must have a diagnosis of onychomycosis **AND** • A failure of an adequate trial of **ONE** oral alternative - terbinafine (6 weeks for fingernail infections; 12 weeks for toenail infections); fluconazole (6 months); itraconazole (60 days for fingernail infections; 90 days for toenail); **OR** • An allergy or contraindication to oral terbinafine, fluconazole or itraconazole;**AND** • Patient is at least 18 years of age or older

Preferred Agents	Non-Preferred Agents	SA Criteria
nystatin Cr **nystatin powder** **nystatin-triamcinolone cr & oint** **terbinafine cr (OTC)** **tolnaftate cr (OTC)** **tolnaftate powder (OTC)** **tolnaftate aero pow (OTC)** **tolnaftate spray (OTC)** **tolnaftate soln (OTC)**	*Fungi-Nail® (OTC)* *Fungoid® Kit (OTC)* *Fungoid® (OTC)* **Jublia®* *ketoconazole foam* **Kerydin®* *Lamisil AT® cr, gel (OTC)* *Lamisil® Spray (OTC)* *Loprox® Shampoo* *Lotrimin AF® cr (OTC)* *Lotrimin AF® (OTC)* *Lotrisone® cr* *Lotrimin Ultra® (OTC)* ***Luzu®* *Mentax®* *Naftin® cr* *Naftin® gel* *Naftifine CR* *Nyata Kit®* *Nizoral A-D® Shampoo (OTC)* *Oxistat® cr* *Oxistat® Lotion* *Pediaderm AF®* *PediPak®* **Penlac®* *Tinactin® Aero Powder (OTC)* *Tinactin® Spray (OTC)* *Vusion®*	** **Clinical Criteria for Luzu® (lulizonazole):** Length of authorization – 3 months • Patient must have a documented diagnosis of athlete's foot (tinea pedis) or ringworm (tinea cruris, tinea corporis); **AND** • A therapeutic failure with at least two (2) topical antifungal drugs; **AND** • Patient is at least 18 years of age or older • Maximum quantity = 60 grams **Topical Onychomycosis Agents SA Fax Form**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Immunomodulators Atopic Dermatitis		
***Elidel®**	**Protopic®* *tacrolimus*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** **Clinical Criteria for Atopic Dermatitis, Topical** ***Elidel® and Protopic®** • Patient must have a FDA approved diagnosis: o Atopic dermatitis o Elidel®: mild to moderate for ages > 2 years. o Protopic® 0.03%: moderate to severe for ages > 2 years. o Protopic® 0.1%: moderate to severe for ages > 18 years; **AND**. • Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)
Psoriasis, Topical		
calcipotriene soln	*calcipotriene cr/oint* *Calcitrene®* *calcitriol* *Dovonex®* **Enstilar ® Foam* *Micanol®* *Sorilux™* *Taclonex®* *Taclonex® Scalp* *Vectical*	**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edit plus** ***Clinical Criteria for Enstilar ® Foam** Length of Authorization: 4 weeks • Diagnosis of plaque psoriasis**; AND** • Minimum age of 18 years**; AND** • Requires a therapeutic failure to at least a **two-week** trial of the preferred drug within the same class.
Steroids		
Steroids, Topical Low Potency		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edit plus** **Clinical Criteria for Steroids** • A therapeutic failure of at least two preferred drugs within the same class.
alclometasone dipropionate cr/oint hydrocortisone/min oil/pet oint hydrocortisone acetate/urea hydrocortisone cr/gel/lot/oint hydrocortisone/aloe gel	*aqua glycolic HC* *Capex® shampoo* *Derma-smoothe-FS* *desonate gel/cr/lot/oint* *Desowen® lot* *fluocinolone 0.01% oil* *Pediaderm® HC* *Pediaderm® TA* *Texacort®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Steroids, Topical Medium Potency		
Fluticasone propionate cr/oint hydrocortisone valerate cr/oint mometasone furoate cr/oint/sol	*betamethasone valerate foam* *clocortolone cr* *Cloderm®* *Cordran® tape* *Cutivate® cr/lot* *Dermatop® cr/oint* *Elocon® cr/oint/soln* *fluocinolone acetonide cr/oint/soln* *fluticasone propionate lot* *hydrocortisone butyrate cr/oint/soln/ emollient* *Luxiq®* *Momexin®* *Pandel®* *prednicarbate cr/oint* *Synalar ®* *Synalar TS®* *Ticanase kit®*	
Steroids, Topical High Potency		
fluocinonide cr/oint/gel soln/emollient triamcinolone acetonide cr/lot/oint	*amcinonide cr/lot/oint* *betamet diprop & prop gly cr/lot/oint* *betamet diprop cr/foam/gel/lot/oint* *betamethasone valerate cr/lot/oint* *DermacinRx® SilaPak™* *DermacinrRX® Silazone* *desoximetasone cr/gel/oint/spray* *diflorasone diacetate cr/oint* *Diprolene® lot/oint* *DiproleneAF®cr* *Halog® cr/oint* *Kenalog® aerosol* *Silazone® II Kit* *Topicort ®cr/gel/oint/spray* *Trianex® oint* *triamcinolone spray*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	triamcinolone/dimethicone *Vanos® cr* *Whytederm® Tdpak*	
Steroids, Topical Very High Potency		
clobetasol emollient **clobetasol propionate cr/gel/ oint/soln** **halobetasol propionate cr/oint**	*Apexicon™ E* *clobetasol lot* *clobetasol propionate foam* *clobetasol propionate spray* *clobetasol shampoo* *Clobex® lot/shampoo/spray* *Clodan® kit* *Halonate®* *Olux®* *Olux®-E* *Temovate® oint* *Ultravate® cr/oint* *Ultravate® PAC* *Ultravate® X*	
Endocrine and Metabolic Agents		
Androgenic Agents (Testosterone – Topical)		
Androgel®	*Androderm®* *Axiron® soln* *Fortesta®* *Natesto Nasal Gel ®* *Testim®* *testosterone (generic for Androgel®)* *testosterone gel/packet/pump (generic for Vogelxo™)* *testosterone (generic for Fortesta®)* *Vogelxo™ gel/packet/pump*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** Failure to respond to a therapeutic trial of at least one week of one preferred drug

Preferred Agents	Non-Preferred Agents	SA Criteria
Antihyperuricemics		

allopurinol
colchicine tabs
Probenecid®
probenecid & colchicine
	colchicine caps
	**Colcrys®*
	Uloric®
	Zyloprim®
		LENGTH OF AUTHORIZATIONS: 1 year
		Routine PDL edit plus
		***Clinical Criteria for Colcrys™**
		• Diagnosis of Familial Mediterranean Fever; **OR**
		• Acute Gout Flare:
		  ○ Trial and failure of one of the following:
		  ▪ NSAID or Corticosteroid

Diabetes Hypoglycemics: Injectable Amylin Analogs		

	**SymLin®*
	**SymLin® Pens*
		LENGTH OF AUTHORIZATIONS: 1 year
		***Clinical Criteria for Injectable Amylin Analogs**
		• Patient must have a history of at least a 90 day trial of insulin.
		• SymLin® is only indicated as adjunct therapy with insulin.
		• Patient meeting ALL of the following criteria may be approved:
		  ○ Diagnosis of Type 1 or 2 diabetes; **AND**
		  ○ On insulin therapy; **AND**
		  ○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%).

Diabetes Hypoglycemics: Injectable Incretin Mimetics		
Byetta®	*Bydureon™* *Tanzeum™* *Trulicity™* *Victoza®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Diabetes Hypoglycemics: Injectable Insulins		
Insulin Mix		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edit**
Humalog® Mix 50/50 vial **Humalog® Mix 75/25 vial** **Humulin® 70/30 vial** **Novolog® Mix 70/30 pen/ vial**	*Humalog® Mix 50/50 Kwikpen* *Humalog® Mix 75/25 Kwikpen* *Humulin® 70/30 pen (OTC)* *Novolin® 70/30 vial (OTC)*	
Insulin N		
Humulin® N vial (OTC)	*Humulin® N pen* *Novolin® N vial (OTC)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Insulin R		
Humulin® R vial	*Novolin® R vial (OTC)*	
Long-Acting Insulins		
Lantus® Solostar® &vial **Levemir® pen/vial**	*Toujeo® Solostar®* *Tresiba® FlexTouch® Pen*	
Rapid-Acting Insulins		
Humulin 500 U/M pen & vial **Humalog® vial** **Novolog® cartridge/ Flexpen/vial**	*Apidra® cartridge/Solostar/vial* *Humalog® Cartridge* *Humalog Kwikpen®* *Afrezza® cartridge (inhalation)*	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
acarbose **Glyset®**	*Precose®*	
Oral Hypoglycemics Biguanides		
metformin **metformin ER** (generic for Glucophage® XR)	*Fortamet®* *Glucophage® IR & XR* *Glutmetza®* *Riomet® susp* *metformin ER (generic Fortamet®)* *metforman ER (generic Glumetza®)*	
Oral Hypoglycemics Biguanide Combination Products		
glyburide/metformin	*glipizide/metformin* *Glucovance®*	
Oral Hypoglycemics DPP-IV Inhibitors & Combination		
Janumet® **Janumet XR®** **Januvia®** **Jentadueto™** **Tradjenta™**	*Kazano™* *Kombiglyze XR™* *Nesina™* *Onglyza™* *Oseni™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Oral Hypoglycemics Meglitinides		
Starlix®	*nateglinide* *Prandin®* *PrandiMet™* *repaglinide/metformin*	
Oral Hypoglycemics Second Generation Sulfonylureas		
glimepiride **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*Amaryl®* *Diabeta®* *Glucotrol®* *Glucotrol XL®* *Glynase®*	
***Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)**		***Clinical Criteria for Oral Hypoglycemics: Sodium Glucose Co-Transporter 2** **Length of Authorization: Initial approval for 6 months. Renewals for 1 year.** • Approve for Type 2 diabetics who have been compliant with and have not achieved adequate glycemic control with metformin; **OR** • Are intolerant to metformin; **AND** • Patient must be > 18 years of age. **Quantity Limit** = 1 tablet per day
Invokana™ **Invokamet™**	*Farxiga™* *Glyxambi®* *Jardiance®* *Synjardy®* *Xigduo™ XR*	
Oral Hypoglycemics Thiazolidinediones		
pioglitazone	*Avandia®* *Actoplus Met® IR & XR* *Actos®* *Avandaryl®* *Avandamet®* *Duetact®* *pioglitazone/metformin*	
Erythropoiesis Stimulating Proteins: Epogen®, Procrit® (Erythropoietin) & Aranesp® (Darbepoetin)		
Procrit®	*Aranesp®* *Epogen®* *Mircera®*	**LENGTH OF AUTHORIZATIONS**: for duration of the prescription up to 6 months **Routine PDL edit** *Omontys® is not PDL eligible, may be covered under medical benefit*

Preferred Agents	Non-Preferred Agents	SA Criteria
Glucocorticoids, Oral		
budesonide EC **dexamethasone soln/tab** **hydrocortisone** **methylprednisolone tab ds pk** **methylprednisolone 4mg tab** **prednisolone sodium phosphate soln** **prednisolone soln/tab** **prednisone soln/tab/tab ds pk**	*Cortef®* *cortisone acetate* *dexamethasone elixir/intensol* *Dexpak®* *Entocort® EC* *Flo-Pred®* *Medrol ®Tab ds pk & tab* *methylprednisolone 8,16 & 32mg tab* *Millipred DP® tab Ds Pk* *Millipred® soln/tab* *Orapred ®ODT* *prednisolone sodium phosphate ODT* *prednisone intensol* *Rayos® DR tab* *Veripred®*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edit plus** Trial and therapeutic failure of all preferred drugs
Growth Hormone		
Genotropin® **Nutropin AQ®** **NuSpin™**	*Humatrope® cartridge/vial* *Norditropin cartridge®* *Norditropin FlexPro®& Nordiflex®* *Nutropin®* *Nutropin AQ® cartridge/vial* *Omnitrope®* *Saizen® cartridge/vial* **Serostim®* *Tev-Tropin®* *Zomacton®* ***Zorbtive®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Clinical Criteria for PEDIATRIC Patients (18 years of age and under)** • Prescriber is an endocrinologist, nephrologist, infectious disease specialist or HIV specialist or one has been consulted on this case; **AND** • The patient has open epiphysis and one of the following diagnoses o Turner Syndrome; **OR** o Prader-Willi Syndrome; **OR** o Renal insufficiency; **OR** o Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old; **OR** o Idiopathic Short Stature (for request for renewal only (a) information is required to be approved); **OR** o Growth hormone deficiency (physician should provide the required information below); **OR** o Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism. • Height is more than 2 SD (standard deviations) below average for the population mean height for age and sex, and a height velocity measured over one year to be

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			1 SD below the mean for chronological age, or for children over two years of age, a decrease in height SD of more than 0.5 over one year; **AND** • Growth hormone response of less than 10ng/mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine, or glucagon. **Clinical Critieria for Renewal (pediatrics):** • For renewal, a response must be documented. Patient must demonstrate improved/normalized growth velocity. (Growth velocity has increased by at least 2 cm in the first year and is greater than 2.5 cm per year); **AND** • Patient height is more than 1 standard deviation (2") below mid-parental height (unless parental height is diminished due to medical or nutritional reasons). **Clinical Criteria for ADULTS (> 18 years of age)** • Prescriber is an endocrinologist; **AND** • Diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when measured by monoclonal antibody (IRMA); **AND** • Cause of growth hormone deficiency is Adult Onset Growth Hormone Deficiency (AO-GHD), alone or with multiple hormone deficiencies, such as hypopituitarism, as a result of hypothalamic or pituitary disease, radiation therapy, surgery or trauma; **OR** • Other hormonal deficiencies (thyroid, cortisol or sex steroids) have been ruled out or stimulation testing would not produce a clinical response such as in a diagnosis of panhypopituitarism. ***Serostim®** • Diagnosis of AIDS wasting or cachexia; **AND** • Has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® & Marinol®); **AND**

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• ***Length of Authorization**: 3 months initial; then 1 year. Renewal is contingent upon improvement in lean body mass or weight measurements. ****<u>Zorbtive®</u>** - Diagnosis of short bowel syndrome **<u>Growth Hormone SA Fax Form</u>**
	Hereditary Angioedema (HAE) Agents		

	Berinert®
	Cinryze™
	Kalbitor®
		Firazyr®
		Ruconest®
			<u>LENGTH OF AUTHORIZATIONS:</u> Date of service (plus one additional supply for emergency use)
			
			Routine PDL edit plus
			
			<u>Clinical Criteria for Blood Modifiers</u>
			• Must be prescribed by and under direct care of a board-certified allergist, immunologist or hematologist; **AND**
			• For prophylaxis the patient must:
			  ○ Have HAE attacks that occur at least once monthly; **AND**
			  ○ Be disabled at least 5 days per month; **AND**
			  ○ Have history of attacks with airway compromise / hospitalization AND
			  ○ Have history of prior prophylaxis with danazol:
			  ▪ danazol contraindicated (pediatric, hepatic or renal impairment, pregnancy, breast-feeding, abnormal genital bleeding); **OR**
			  ▪ Developed danazol toxicity; **OR**
			  ▪ Diminished danazol efficacy.
			
			<u>FDA Indications and Quantity Limits</u>
			• Berinert®: Acute abdominal, facial or laryngeal HAE attacks. Four vials per attack (plus four for emergency).
			• Cinryze™: Prevention of HAE attacks. 20 vials per 34 days.
			• Kalbitor®: Acute HAE attacks in patients 12 years of age and older. Three vials per attack (plus three vials for emergency).
			• Firazyr® Acute attacks of (HAE) in adults 18 years of age and older. One syringe (plus one for emergency).
			• Ruconest® Acute attacks of hereditary angioedema (HAE) in people over 13 years of age. Two vials (plus two for emergency).
			<u>Hereditary Angioedema (HAE) SA Fax Form</u>

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Pancreatic Enzymes		
	***pancrelipase** ***Zenpep®** ***Creon®**	*Pancreaze®* *Viokace®* *Pertzye®* *Ultresa®*	**LENGTH OF AUTHORIZATION:** 1 year **Routine PDL edit plus** **Clinical Criteria for Pancreatic Enzymes** ***Creon®, Pancrelipase, Zenpep®:** diagnosis of pancreatic insufficiency due to cystic fibrosis or chronic pancreatitis or pancreatectomy. • For all drugs if member has a diagnosis of Cystic Fibrosis they do not have to try and fail a preferred. • If member has a feeding tube then two different pancreatic enzymes can be approved for use together.
	Progestational Agents		
	medroxyprogesterone acetate (tablet only) **norethindrone acetate** **progesterone injection** **Prometrium®**	*Aygestin®* *progesterone cap* *Provera®*	**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edit plus** Failure to respond to a therapeutic trial of at least one week of one preferred product.
	Progestins Used For Cachexia		
	megestrol acetate	*Megace®* *Megace® ES* *megestrol suspension ES*	**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edit**
	Vaginal/Oral Estrogens		
	Premarin® Vaginal cr **Vagifem® Vaginal tab**	*Estrace ®Vaginal cr* *Estring® Vaginal ring* *Femring® Vaginal ring* *Osphena® tab*	**LENGTH OF AUTHORIZATIONS:** 6 months **Routine PDL edit**
Gastrointestinal			
	G I Antibiotics		
	metronidazole tab **Vancocin®**	**Alinia®* ***Dificid®* *Flagyl® cap, tab & ER* *metronidazole cap* ****neomycin* *paromomycin* *Tindamax®*	**Length of authorization:** 1 year **Routine PDL edit plus**

	Preferred Agents	Non-Preferred Agents	SA Criteria

		tinidazole
		*****Xifaxan®*
		vancomycin capsules
		vancomycin compounded oral solution
			Clinical Criteria for Gastrointestinal Antibiotics
			
			***Alinia®:**
			• Tablets - For treatment of of diarrhea caused by
			  ○ *Cryptosporidium parvum* or *Giardia lamblia* and if the patient has had a trial on metronidazole or oral vancomycin or a clinical reason why it cannot be tried. Length of authorization = date of service Quantity limit = 6 tabs per rolling 30 days
			• Suspension:
			  ○ In patients ≥ 12 for treatment of diarrhea caused by *Cryptosporidium parvum* or *Giardia lamblia* and if the patient has had a trial on metronidazole or oral vancomycin or a clinical reason why it cannot be tried. Length of authorization = date of service
			In patients < 12 for treatment of diarrhea caused by *Cryptosporidium parvum* or *Giardia lamblia* – no trial on metronidazole or oral vancomycin required. Length of authorization = date of service
			
			****Dificid®:** diagnosis of *C. difficile* and if the patient has had a 10 day trial of oral vancomycin or metronidazole or a clinical reason why it cannot be tried; length of authorization = 30 days. Patient must be >17 years old.
			
			*****Neomycin:** diagnosis of hepatic coma – no preferred trial required. Length of authorization = one year.
			
			******Xifaxan®**
			Length of authorization: one year.
			• Xifaxan 200mg tabs:
			  ○ For treatment of travelers' diarrhea caused by noninvasive strains of *E. coli*, in patients greater than or equal to 12 years of age - no prior authorization is required for up to nine tablets per claim. Length of authorization = 3 days.
			  ○ For treatment of hepatic encephalopathy – may be approved for patients age 12 and older regardless of quantity requested (document all treatments tried in the past for this diagnosis). 550mg tabs:
			
			Length of Authorization: 6 months for IBS with diarrhea
			Xifaxan 550mg
			• Diagnosis of irritable bowel syndrome with diarrhea (IBS-D).
			• Patient age ≥ 18 years

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• Patient has had chronic IBS-D symptoms for at least 6 months; **AND** ○ Patient has tried and failed at ***least three agents from*** the following ○ Bulk producing agents (e.g., psyllium, fiber); AND ○ Antispasmodic agents (e.g., dicyclomine, hyoscyamine); AND ○ Antidiarrheal agents/opiates (e.g., loperamide, diphenoxaylate/atropine).
Antiemetic/Antivertigo Agents			
Cannabinoids (delta-9THC derivatives)			**LENGTH OF AUTHORIZATIONS:** 6 months **Routine PDL edit plus** **Clinical Criteria for Cannabinoids** ***Cesamet®** • Diagnosis of severe, chemotherapy induced nausea and vomiting, **AND** • Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend® plus a 5HT3 receptor antagonist plus a corticosteroid; **AND** • Patient has tried and failed megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction, or medical reason megestrol acetate cannot be used. ****Dronabinol** • Diagnosis of severe, chemotherapy induced nausea and vomiting, **AND** • Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend® plus a 5HT3 receptor antagonist plus a corticosteroid; **AND** • Diagnosis of AIDS-relating wasting Patient has tried and failed megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction; **OR** • Medical reason megestrol acetate cannot be used.
	**dronabinol	*Cesamet® **Marinol ®	

Preferred Agents	Non-Preferred Agents	SA Criteria
5HT3 Receptor Blockers		**LENGTH OF AUTHORIZATIONS:** 3 months, unless otherwise noted **Routine PDL edit plus** ***Clinical Criteria for 5HT3 Receptor Blockers:** • Nausea or vomiting related to radiation therapy, moderate to highly emetogenic chemotherapy, or post-operative nausea and vomiting; **AND** • Patient has tried and failed therapeutic doses of, or has adverse effects or contraindications to, 2 different conventional antiemetics (e.g., promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone, etc.)
ondansetron ODT/tab	*Anzemet® *Akynzeo® *granisetron *Granisol® soln/tab *Kytril® ondansetron soln *Sancuso® ® patch Zofran®ODT/soln/tab *Zuplenz® film	
NK-1 Receptor Antagonist		**LENGTH OF AUTHORIZATIONS:** Length of chemotherapy regimen or a maximum of 6 months **Routine PDL edit plus** **Clinical Criteria for NK-1 Receptor Antagonist** ****Emend® (aprepitant)** • Emend® does NOT require treatment failure with preferred drugs when used for moderately or highly emetogenic chemotherapy. Quantity limits: One (1) Emend® BiPack (2-80mg tablets) per chemotherapy treatment or one (1) Emend® TriPack (1-125mg tablet and 2-80mg tablets) per chemotherapy treatment. *****Varubi ™** Length of Authorization: Length of chemotherapy regimen or a maximum of 6 months • Varubi does NOT require treatment failure with preferred drugs when used for moderately or highly emetogenic chemotherapy. • Indicated in combination with other antiemetic agents in adults for the prevention of delayed nausea and vomiting associated with initial and repeat courses of emetogenic cancer chemotherapy, including, but not limited to, highly emetogenic chemotherapy.
	Emend®Bi Pak **Emend® Tri-fold pack *****Varubi ™	

Preferred Agents	Non-Preferred Agents	SA Criteria
Other		**LENGTH OF AUTHORIZATIONS**: 1 year, unless otherwise noted **Routine PDL edit plus** **Clinical Criteria for Antiemetics/Antivertigo, Other** ***Diclegis® (doxylamine/pyridoxine)** • Patient must be pregnant ****Promethazine** • Patient must be 2 years or older *****Transderm-Scop®** may be approved for 3 months if patient: • has tried and failed at least one of the following: meclizine, promethazine, dimenhydrinate, diphenhydramine, or metoclopramide; **OR** • is unable to swallow or absorb oral drugs, **OR** • will be in an area/situation for an extended period of time where taking short acting agents would not be feasible **Antiemetic-Antivertigo SA Fax Form**
meclizine **metoclopramide** **ondansetron tab & ODT** **prochlorperazine** ****promethazine**	*Antivert®* *Compazine®supp/tab* *Compro®* **Diclegis®* *dimenhydrinate* *hydroxyzine* *Metozolv® ODT* metoclopramide ODT *****Phenergan®* *prochlorperazine supp* *promethazine 50mg Rectal* *Reglan®* *Tigan®* ******Transderm-Scop®* *trimethobenzamide* *Vistaril®*	
GI Motility, Chronic		

***Amitiza®**	******alosetron*
	*****Linzess™*
	******Lotronex®*
	*******Movantik®*
	********Relistor®*
	*********Viberzi™*
		LENGTH OF AUTHORIZATIONS: 6 months
		Routine PDL edit plus
		
		Clinical Criteria
		***Amitiza®**
		• Must be 18 or older, **AND**
		• have one of the following diagnoses
		  • Idiopathic Constipation with treatment failure of at least ONE product from TWO of the following classes:
		  ▪ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol); **OR**
		  ▪ Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, fiber); **OR**
		  ▪ Stimulant Laxatives (examples: bisacodyl, senna).
		  • Constipation Predominant Irritable Bowel Syndrome (IBS-C)
		  ▪ Patient is female; **AND**
		  ▪ Treatment failure on at least ONE product from TWO of the following

	Preferred Agents	Non-Preferred Agents	SA Criteria
			classes: ▪ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol) ▪ Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, fiber) ▪ Stimulant Laxatives (examples: bisacodyl, senna) • Opioid Induced Constipation in chronic NON-cancer pain ▪ Patient has tried and failed both PEG (i.e., Miralax®) AND lactulose **<u>Linzess</u>® • Diagnosis of Idiopathic Chronic Constipation or Constipation-Predominant Irritable Bowel Syndrome (IBS); **AND** • Patient must be at least 6 years of age; **AND** • Treatment failure on at least ONE agent from TWO of the following classes: o Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol); **OR** o Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, fiber); **OR** o Stimulant Laxatives (examples: bisacodyl, senna). ***<u>Lotronex</u>® (alosetron) • Diagnosis of severe, diarrhea predominant Irritable Bowel Syndrome; **AND** • Patient is female and at least 18 years of age; **AND** • Prescriber is enrolled in the Promethus Prescribing Program for Lotronex®; **AND** • Patient has had chronic IBS symptoms for at least 6 months; **AND** • Patient has tried and failed at least three agents from the following o bulk producing agents (e.g., psyllium, fiber); **OR** o antispasmodic agents (e.g., dicyclomine, hyoscyamine); **OR** o antidiarrheal agents/opiates (e.g., loperamide, diphenoxaylate/atropine, codeine). ****<u>Movantik</u>® • For the treatment of Opioid-Induced Constipation in adult patients with chronic NON-cancer pain with trial on both polyethylene glycol (PEG) **AND** lactulose without adequate response; **AND**

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• A therapeutic failure after a trial with Amitiza® **OR** clinical reason as to why Amitiza cannot be used; **AND** • The patient is 18 years of age or older. *******Relistor®** • Diagnosis of Opioid-Induced Constipation in o Adult patients with chronic non-cancer pain; **OR** o Adult patients with advanced illness; **AND** • Patient must be ≥ 18 years. *******Viberzi™* Length of Authorization: 1 year • Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) ; **AND** • Patient age ≥ 18 years; **AND** • Patient has had chronic IBS-D symptoms for at least 6 months; **AND** o Patient has tried and failed at least three agents from the following ; **AND** o Bulk producing agents (e.g., psyllium, fiber); OR o Antispasmodic agents (e.g., dicyclomine, hyoscyamine); OR o Antidiarrheal agents/opiates (e.g., loperamide, diphenoxaylate/atropine, codeine). • Patient should not have the following conditions: o Known or suspected biliary duct obstruction o Sphincter of Oddi disease or dysfunction o Alcoholism, alcohol abuse, alcohol addiction, or drink more than 3 alcoholic beverages daily o History of pancreatitis; structural diseases of the pancreas, including known or suspected pancreatic duct obstruction o Severe hepatic impairment (Child-Pugh Class C) o Chronic or severe constipation, sequelae from constipation, or known or suspected mechanical gastrointestinal obstruction • Patients without a gallbladder who are receiving concomitant OATP1B1 inhibitors, or have mild (Child-Pugh Class A) or moderate (Child-Pugh Class B) hepatic impairment, should receive 75 mg twice daily. **Bowel Disorder SA Fax Form**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
H. Pylori Treatment		
Pylera®	*Omeclamox*®*-Pak* *lansoprazole/amoxicillin/clarithromycin* *Prevpac*®	**LENGTH OF AUTHORIZATIONS**: 14 days **Routine PDL edit**
Histamine-2 Receptor Antagonists (H-2 RA)		
famotidine (OTC & RX) **ranitidine tab/syrup (OTC & RX)**	*cimetidine tab/syrup (OTC/RX)* *famotidine oral susp (OTC/RX)* *nizatidine cap/susp* *Pepcid* ® *susp/tab (OTC/RX)* *ranitidine cap (OTC/RX)* *Zantac*® *syrup/ tab (OTC/RX)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Proton Pump Inhibitors		
omeprazole (RX & OTC) **pantoprazole**	*Aciphex*® *DR tab/sprinkle* *Dexilant*® *esomeprazole magnesium* *esomeprazole strontium* *lansoprazole cap* *Nexium*® *omeprazole/sodium bicarbonate* *Prevacid*® *RX, OTC& Solutab* *rabeprazole DR tab* *Prilosec® Rx & Susp* *Prilosec*® *OTC (nonrebatable)* *Protonix*® *Zegerid*® *cap, OTC & susp packet*	**LENGTH OF AUTHORIZATIONS**: 12 weeks; unless patient meets an exception; then 1 year **Routine PDL edit plus** **Clinical Criteria for PPIs** • A therapeutic failure of no less than a **three-month trial** of **at least two different preferred** drugs within the same class. **Exceptions that allow for a 1 year SA for PPIs** (Exceptions apply to the duration of the SA only. PDL edit still prevails before a non-preferred may be approved) • Erosive Esophagitis • Active GI Bleed • Zollinger-Ellison Syndrome • Greater than 65 years of age • Under the care of a Gastroenterologist and has ruled out a nonsecretory condition **Proton Pump Inhibitors SA Fax Form**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)		
	Ulcerative Colitis – Oral		**LENGTH OF AUTHORIZATIONS:** **1 year**
	Apriso® **Pentasa®** **sulfasalazine DR & IR**	*Asacol ®HD* *Azulfidine® IR &DR* *balsalazide disodium* *Colazal®* *Delzicol™* *Dipentum* **Giazo™* *Lialda ®* *Uceris™*	**Routine PDL edit** *Giazo is limited to an 8 week supply
	Ulcerative Colitis – Rectal		
	Canasa® rectal supp **mesalamine enema**	*mesalamine kit* *Rowasa® enema/kit* *SFRowasa®* *Uceris®*	
Genitourinary			
	Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)		
	Alpha-Blockers for BPH		**LENGTH OF AUTHORIZATIONS:** **1 year**
	alfuzosin **tamsulosin HCL**	*Flomax ®* *Rapaflo®* *Uroxatral®*	**Routine PDL edit plus**
	Androgen Hormone Inhibitors for BPH		
	finasteride	*Avodart ®* *Dutasteride* *Dutasteride./tamsulosin* *Jalyn®* *Proscar®*	
	Phosphodiesterase (PDE) 5 Inhibitor for BPH		****Step edit for Cialis® -** must try and fail both Alpha Blockers and Androgen Hormone Inhibitors for BPH and the prescriber must attest that the patient is not on the state list of sex offenders. The patient must have had a consult or been evaluated by an Urologist. **Cialis SA Fax Form**
		***Cialis®*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Urinary Antispasmodics (Bladder Relaxant)		
	oxybutynin tab/syrup **Toviaz™** **VESIcare®**	*Detrol® & Detrol® LA* *Ditropan® & *Ditropan® XL* *Enablex®* *flavoxate* *Gelnique™ gel* *Myrbetriq™* **oxybutynin ER* *Oxytrol® transdermal* *Sanctura XR* *trospium IR & ER* *tolterodine IR & ER*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** ***Clinical Criteria for Oxybutynin ER, Ditropan XL®:** • Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder.
	Immunological Agents		
	Multiple Sclerosis		
	Avonex® **Avonex® Adm Pack** **Betaseron®** **Copaxone 20 mg syringe®** ****Gilenya®** **Rebif® SQ**	**Ampyra®* *Aubagio®* *Copaxone® 40 mg syringe®* *Extavia® Kit* *Glatopa™* *Plegridy®* *Rebif® Rebi dose Pen®* *Tecfidera™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** ****Gilenya®** is the preferred oral agent after a a trial on a preferred Injectable agent. To clarify: to receive one of the other non-preferred oral agents both an Injectable preferred and Gilenya® must be tried and failed. ***Clinical Criteria for AMPYRA®** • The patient has a diagnosis of Multiple Sclerosis and a gait disorder, **AND** • Patient has no history of seizures; AND • Patient's Creatinine Clearance [CrCL] ≥ 50 mL/min; **AND** • If after 8 week trial the prescriber states that the patient showed improvement or that the drug was effective (by improved Timed 25-foot Walk), the patient may receive authorization for Ampyra® for one year. **Ampyra SA Fax Form**
	Cytokine and CAM Antagonists And Related Agents		
	Enbrel® **Humira®**	*Actemra® SQ* *Cimzia®* *Cimzia® Syringe Kit* *Cosentyx™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit plus Clinical Criteria (see Appendix A)**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Kineret® *Otezla*® *Otrexup*® *inj* *Orencia*® *Rasuvo*™*inj* *Simponi*® *Xeljanz*™	**Cytokine and CAM Antagonists Appendix A** **Otrexup SA Fax Form** **Xeljanz SA Fax Form**
Ophthalmic			
	Antibiotics		
	ciprofloxacin drops **erythromycin** **gentamicin drops/oint** **Moxeza® drops** **neomycin/polymix/gramicidin** **ofloxacin drops** **polymyxin/trimethoprim** **sulfacetamide soln** **tobramycin** **Vigamox® drops**	*AzaSite™ drop* *bacitracin* *bacitracin/polymyxin b sulfate oint* *Besivance® drops* *Bleph®-10* *Ciloxan® drops/oint* *Garamycin ®drops/oint* *gatifloxacin 0.5% soln* *Ilotycin®* *levofloxacin drops* *Natacyn®* *neomycin/bacitracin/polymyxin oint* *Neosporin ®* *Ocuflox® drops* *Polytrim®* *sulfacetamide oint* *Tobrex® drops/oint* *Zymaxid® drops*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edit**
	Antibiotic/Steroid Combinations		
	neomycin/polymyxin/dexamethasone oint/susp **Tobradex® oint/susp**	*Blephamide®* *Blephamide® S.O.P.* *Maxitrol® oint/susp* *neomycin/bacitracin/poly/HC* *neomycin/polymyxin/HC*	**LENGTH OF AUTHORIZATION**: Date of service only; no refills **Routine PDL edit**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Pred-G® oint/susp *sulfacetamide/prednisolone* *Tobradex® ST* *Tobramycin/dexamethasone susp* *Zylet®*	
Antihistamines/Mast Cell Stabilizers		
Antihistamines		**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edit** *Ilevro™ is limited to 1 bottle plus 1 refill
Alaway OTC® **ketotifen fumerate** **Pataday® drops** **Pazeo®** **Zaditor® OTC drops**	*azelastine drops* *Bepreve®* *Elestat® drops* *Emadine® drop* *epinastine 0.05% eye drops* **Ilevro™ 0.3% drops* *Lastacaft® drops* *olopatadine* *Optivar® drops* *Patanol® drops*	
Mast Cell Stabilizers		
cromolyn sodium	*Alocril® drops* *Alomide® drops*	
Anti-inflammatory		
NSAIDS		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edit** *Ilevro™ is limited to 1 bottle plus 1 refill
diclofenac sodium **flurbiprofen sodium** **ketorolac 0.4%& 0.5%** **Nevanac®**	*Acular® 0.5% & LS® 0.4%* *Acuvail®* *bromfenac 0.09%* *Ilevro™0.3% drops* *Ocufen®* *Prolensa™*	
Corticosteriods		
Durezol® **fluorometholone** **prednisolone acetate** **dexamethasone**	*Alrex™* *Flarex®* *FML®* *FML Forte® & FML® S.O.P.* *Lotemax™ drops/gel/oint*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Maxidex® *Omnipred®* *Pred Forte®* *Pred Mild®* *prednisolone sod phosphate* *Vexol®*	
Glaucoma Agents		
Alpha 2 Adrenergic Agents		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
apraclonidine 0.5% drops **Alphagan P® 0.1 & 0.15%** **brimonidine 0.2%**	*brimonidine tartrate 0.15%* *Iopidine® 0.5% & 1%*	
Beta Blockers		
Betoptic-S® 0.25% **carteolol 1%** **Combigan®** **levobunolol 0.5%** **metipranolol 0.3%** **timolol maleate**	*Betagan® 0.5%* *betaxolol 0.5%* *Istalol® 0.5%* *Timoptic® drops 0.25% & 0.5%* *Timoptic® XE 0.25% & 0.5% sol-gel*	
Carbonic Anhydrase Inhibitors		
Azopt® 1% **dorzolamide** **dorzolamide/timolol** **Simbrinza™**	*Cosopt® 0.5%-2%* *Cosopt® PF* *Trusopt® 2%*	
Prostaglandin Analogs		
latanoprost **Travatan Z®**	*bimatoprost* *Lumigan® 0.03% & 0.01%* *Rescula®* *travoprost 0.004%* *Xalatan® 0.005%* *Zioptan™*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Respiratory			
	Anti-Allergens, Oral		
		**Grastek® SL* ***Oralair® SL* ****Ragwitek™ SL*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** **Clinical Criteria for *Grastek®** • Age must be between 5 through 65 years, **AND** • Indicated for grass pollen-induced allergic rhinitis with or without conjunctivitis; **AND** • Must have evidence of a confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens; **AND** • Must have had a treatment failure with or contraindication to antihistamines and montelukast; **AND** • Clinical reason as to why allergy shots cannot be used. • Quantity Limit = 1 sublingual tablet per day. **Clinical Criteria for **Oralair®** • Age must be between 10 through 65 years; **AND** • Indicated for grass pollen-induced allergic rhinitis with or without conjunctivitis; **AND** • Must have evidence of a confirmed positive skin test or in vitro testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens; **AND** • Must have had a treatment failure with or contraindication to antihistamines and montelukast, **AND** • Clinical reason as to why allergy shots cannot be used. **Clinical Criteria for ***Ragwitek™** • Age must be between 18 through 65 years; **AND** • Indicated for immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis; **AND** • Must have evidence of a confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen; **AND**

Preferred Agents	Non-Preferred Agents	SA Criteria
		• Must have had a treatment failure with or contraindication to antihistamines and montelukast; **AND** • Clinical reason as to why allergy shots cannot be used.
Antihistamines: First and Second Generation		
First Generation Antihistamines		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Generic only class	*All Brands require a SA*	
Second Generation Antihistamines and Combinations		
cetirizine liquid 1mg/1mL (RX/ OTC) **cetirizine tabs OTC** **loratadine tab/syrup OTC**	*Allegra-D®* *cetirizine chew tab (OTC)* *cetirizine liquid 5mg/5mL (OTC)* *cetirizine D tab (OTC)* *Clarinex®* *Clarinex-D®* *Claritin®* *Claritin® D* *desloratadine ODT* *fexofenadine* *fexofenadine/PSE ER* *fexofenadine suspension* *levocetirizine* *loratadine ODT* *loratadine D 12 & 24 hr* *Xyzal®*	
Beta-Adrenergic Agents		
Long Acting Beta Adrenergic agents (LABA) Metered Dose Inhalers or Nebulizers		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** ****Clinical Criteria for agents that contain a LABA** **Length of Authorization: 3 months for Clinical Criteria** (see next page)
***Foradil®** ***Serevent Diskus®**	**Arcapta Neohaler®* **Brovana®* **Perforomist®* *Striverdi® Respimat*	

Preferred Agents	Non-Preferred Agents	SA Criteria
		Each product listed below will require a SA for ages less than the FDA/PI indicated age

Brand Name	Age where SA is required	Drug indicated
Advair ®Diskus2 50/50, & 500/50	Children < 12	Asthma & COPD
Advair® Diskus 100/50	Children < 4	Asthma & COPD
Advair ®HFA	Children < 12	Asthma & COPD
Anoro™ Ellipta	Children & Adolescents < 18	COPD only
Arcapta® Neohaler	Children & Adolescents < 18	COPD only
Breo®Ellipta™	Children < 18 y	Asthma & COPD
Brovana®	Children & Adolescents < 18	COPD only
Dulera®	Children < 12	Asthma only
Foradil® Aerolizer	Children < 5	Asthma & COPD
Perforomist®	Children & Adolescents < 18	COPD only
Serevent® Diskus	Children < 4	Asthma & COPD
Symbicort®	Children < 12	Asthma & COPD
Striverdi® Respimat	Children < 18 years	COPD only
Stiolto™ Respimat®	Children < 18 years	COPD only

Short Acting Metered Dose Inhalers or Devices	
Proair® HFA **Proventil® HFA**	*ProAir® RespiClick* *Ventolin® HFA* *Xopenex® HFA*
Short Acting Nebulizers	
albuterol sulfate (all premix dosage forms) **metaproterenol** **Xopenex®**	*levalbuterol soln*

Preferred Agents	Non-Preferred Agents	SA Criteria
COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors		
Atrovent HFA® **Combivent® Respimat** **ipratropium bromide soln** **ipratropium/albuterol nebs** **Spiriva®**	*Anoro™ Ellipta®* *Daliresp®* *Incruse™ Ellipta®* *Tudorza™* *Stiolto Respimat™* *Spiriva® Respimat* *Seebri Neohaler™* *Utibron Neohaler™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit plus** **Clinical Criteria for Daliresp®** • If the patient has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations; **AND** • Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids); **AND** • Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent).
Corticosteroids: Inhaled and Nasal Steroids		
Inhaled Corticosteroids: Combination Products (Glucocorticoid and Long Acting Beta Adrenergic)		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
***Advair® Diskus** ***Dulera®** ***Symbicort®**	Advair® HFA *Breo®Ellipta™*	
Inhaled Corticosteroids: Metered Dose Inhalers		
Asmanex® **Flovent® Diskus & HFA** **Pulmicort Flexhaler®** **QVAR®**	*Alvesco®* *Aerospan™* *Arnuity™ Ellipta®* *Asmanex HFA®*	
Inhaled Corticosteroids: Nebulizer Solution		
Pulmicort® Respules	*Budesonide*	
Nasal Steroids		
Nasonex® **fluticasone**	*Beconase AQ®* *Budesonide (generic for Rhinocort Aqua)* *Children's Qnasl™* *Dymista™* *Flonase®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	flunisolide *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *Ticanase®* *triamcinolone acetonide* *Veramyst®* *Zetonna™*	
Cough and Cold products		
Ala-Hist DM **benzonatate cap** **codeine/ promethazine** **guaifenesin/codeine phosphate** **hydrocodone/ homatropine** **Iophen-C NR** **Lohist-DM syrup** **phenylephrine HCl/promethazine HCl** **promethazine DM syrup** **Tusnel® Pediatric Drops**	*All other Legend cough and cold products are non-preferred* *Tessalon ® perle*	**LENGTH OF AUTHORIZATION**: Date of Service Only **Routine PDL edit** **Clinical Edit for Cough and Cold Agents – Children under the age of 6 years are not eligible for cough and cold products.**
Epinephrine, Self-Injected		
epinephrine **Epipen®** **Epipen® Jr**	*Auvi-Q™*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edit**
Intranasal Antihistamines		
Patanase®	*Astepro® 0.15%* *azelastine 0.1%* *olopatadine*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Leukotriene Receptor Antagonists		
	montelukast tabs/chew tabs	*Accolate®* *Singulair® tabs/chew tabs/granules* *montelukast granules* *zafirlukast* *Zyflo™* *Zyflo CR™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**